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IMPACT OF TRANSITIONING TO THE U.S. ON KOREANS' HEALTH BEHAVIORS AND WELL-BEING

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IMPACT OF TRANSITIONING TO THE U.S.

ON KOREANS' HEALTH BEHAVIORS AND WELL-BEING

By

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Dedication

This study is dedicated to my family, teachers, and friends for their unconditional support and encouragement, as well as to Korean immigrants and all immigrants who are struggling to integrate into a new country.

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Impact of Transitioning to the U.S. on Koreans' Health Behaviors and Well-Being

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Immigration transition may be an opportunity for physical, psychological, and social improvement, but the health of transitioning individuals may actually be at an increased risk for decline. In order to overcome negative influencing factors on the health of immigrants trying to integrate into a new society, examining the impact of transitioning immigration on the health of immigrants is important. Transition has complex and multidimensional patterns based on an individual's social and cultural background. Korean immigrants in transitioning to the U.S. have experienced a specific and unique situation. Thus, the primary purpose of this study was to identify the impact of immigration transition, which is defined in the middle-range theory of transition, on the health-promoting behaviors and mental well-being of Korean immigrants in the U.S.

A cross-sectional, descriptive correlational comparative design was used for examining a total of 192 Koreans: 105 in the U.S. and 87 in S. Korea, which were selected through matched age and gender controls with Korean immigrant participants in

the U.S. The average ages were 46.8 (*Median* = 47, *SD* = 12.5) of Korean immigrants in the U.S and 46.2 (*Median* = 46, *SD* = 12.7) of 87 native S. Koreans.

Korean immigrants had a low level of acculturation and limited English proficiency. The level of health-promoting behaviors of Korean immigrants was higher than that of S. Koreans, especially in subscales of health promotion, nutrition, and safety. Social resourcefulness was a key predictor of health-promoting behaviors and mental well-being among Korean immigrants. Also, self-control was a dominant mediator on the relationship between behavioral acculturation and mental well-being.

Increasing acculturation and English ability for Korean immigrants, as well as increasing self-control, family functioning, and social resourcefulness were found to be important to improve integrating Korean immigrants into the U.S. These findings provide essential information that all health care professionals can use to increase their awareness of the importance of appropriately treating individuals with different cultural perspectives as well as diverse populations coming from varied countries.

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CHAPTER 1: INTRODUCTION

The movement of an individual from one country to another is more than a simple transition of physical location; it is a movement in mind and body that can have severe and lasting consequences for physical and mental health. According to 2010 statistics, approximately 40 million foreign-born individuals reside in the United States (U.S., U.S. Census, 2010). Their immigration transition may be an opportunity for physical, psychological, and social improvement, but the health of these transitioning individuals may actually be at an increased risk for decline.

The transition to a new country is connected with diverse changes in psychological, social, and cultural aspects of immigrants' lives and health, resulting in fresh attitudes, beliefs, and behaviors. Indeed, the changes in immigrants' lifestyles begin as soon as they arrive in the U.S., when they are exposed to new languages, diets, jobs, housing, social policies, and relationships (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000; Derose, Escarce, & Lurie, 2007; Dey & Lucas, 2006; Holmes, 2006; Huang, Yu, & Ledsky, 2006). These changes, evoked in the resettlement process, may affect subjective well-being and health-promoting behaviors of immigrants.

Though there are many immigrant groups, Korean immigrants are one of the fastest growing groups in the U.S. (Jo, Maxwell, Rick, Cha, & Bastani, 2009), and this population has relatively poor health practices related to diet, body weight, and women's smoking patterns (Lee, Fogg, & Sadler, 2006; Sohng, Sohng, & Yeom, 2002). Also, a lack of medical insurance and limited access to medical care exacerbate the health issues of Korean immigrants (Kim et al., 2009; Mui, Kang, Kang, & Domanski, 2007; Shin, &

Bruno, 2003), who are already socially isolated from mainstream society by language and cultural barriers. Thus, in order to overcome factors that negatively impact the health of Korean immigrants trying to integrate into mainstream society in the U.S., it is important to examine their immigration transition.

In this study, the researcher proposed to identify health-promoting behaviors and well-being of Korean immigrants and to explore any relationship between their health and the immigration transition. Specifically, this study explained the effects of the immigration transition by examining the associations between acculturation and health behaviors and mental well-being. The knowledge from this study will help guide the development of culturally proficient interventions for relocated immigrants. A lack of cultural understanding about Korean immigrants could result in less than adequate care for their health due to inadequate or inappropriate advice on their lifestyle choices, which may impede their opportunity to live healthy lives after immigrating to a new country. This study involving Korean immigrants may be of help in understanding various immigrant groups as they transition into American society.

Purpose of the Study

This study explored the impact of immigration transition, which is defined in transition theory (Meleis, Sawyer, Im, Messias, & Schumacher, 2000), on the health-promoting behaviors and mental well-being of Korean immigrants in the U.S. The primary purpose of this study was to explore the influences of immigration transition on Koreans in the U.S.

This was done through four main aims. First, the researcher proposed to examine the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S. and South (S.) Korea. Second, this study aimed to compare differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Koreans in the U.S. and in S. Korea. Third, this study identified the significant predictors of health-promoting behaviors and mental well-being for Koreans in the U.S and in S. Korea. Finally, the researcher proposed to determine mediating effects of self-control, family functioning, and social resourcefulness on the relationships between acculturation and health-promoting behaviors and mental well-being among Koreans in the U.S. Although it is beyond the scope of this dissertation to directly measure the impact and degree of impact of the immigration transition on Koreans as they migrate to the U.S., this study will begin a conversation on influences and changes that might be worthy of further exploration on predictors of health and illness.

Background and Significance

Immigration unavoidably influences a transition in an individual's lifestyle, and it changes his or her beliefs and values related to health and illness, which are characterized by culture (Knott, 2002; Spector, 2004). These changes influence health-related behaviors and lifestyle choices, which ultimately determine immigrants' overall health and well-being. Health is a multi-dimensional concept; it is defined as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (World Health Organization [WHO], 1958, p. 459).

The immigration transition is uniquely experienced and expressed by each immigrant group that shares cultural meaning and behaviors. Immigrants face multiple changes in the social, psychological, and cultural aspects of their lives. Culture refers to the knowledge and attitudes that people learn and develop to understand experiences and social norms (Spradley, 1972). As part of the immigration transition, they naturally experience acculturation and adaptation to the host country, which in turn influences their attitudes, beliefs, and behaviors (Berry & Sam, 1997). Acculturation is defined as "those phenomena which result when groups of individuals having different cultures come into continuous firsthand contact, with subsequent changes in the original culture patterns of either or both groups" (Redfield, Linton & Herskovits, 1936, p.149).

Transition is defined as changing from one state of being to another according to Merriam-Webster's collegiate dictionary (2012). Chick and Meleis (1986) defined transition as "a passage from one life phase, condition, or status to another … transition refers to both the process and the outcome of complex person environment interactions"

(pp. 239-240). Thus, immigration transition may be an opportunity for physical, psychological, and social improvement. On the other hand, the health of lifestyle transitioning individuals may be at an increased risk. The transitioning in the lifestyle of immigrants that occurs in the resettlement process may affect immigrants' overall health and health needs in combination with various other factors that influence health.

Within the U.S. immigrants' population, which reached approximately 40 million in 2010, the highest in U.S. history, Korean immigrants have become a quickly growing minority group (Jo et al., 2009). The impact of Korean immigrants' transitioning has been widely studied in cultural contexts. Regardless, studies with cultural contexts on this population are limited in some aspects. The studies reviewed lacked essential definitions of cultural concepts and assumed that readers would use their knowledge base as a frame of reference (e.g., Jang, Kim, Chiriboga, & Kallimanis, 2007; Lee, Sobal, & Frongillo, 2000, 2003). The concept of culture is unique and distinctive in every ethnic group and the impact of culture depends on the country; however, the majority of studies used scale-based measures originally designed for use with other ethnic groups, not for Korean immigrants in the U.S. (e.g., Kim, Han, Shin, Kim, & Lee, 2005; Lee, Moon, & Knight, 2004; Shin, Song, Kim, & Probst, 2005). Further, the cultural effect on health outcomes and health-related behaviors is not consistent across various studies, which indicates discordant results that can lead to hasty generalizations about Korean immigrants' transitioning experiences (e.g., Kim & Cain, 2008; Lee et al., 2000; Song et al., 2004). Lack of appropriate measurements for Korean Americans may yield inconsistent findings and mislead researchers about Korean immigrants' health and health behaviors.

The U.S. national health data sets are frequently used to guide health care planning and education for the growing population of Korean immigrants. However, national health data collected in the U.S. shows a lack of data for this individual ethnic minority because Korean Americans are often treated homogenously with other Asian groups (Biederman et al., 2001; Mosca et al., 2000). Some studies on the effect of acculturation on health outcomes and health-related behaviors show inconsistent findings (Black & Markides, 1993; Otero-Sabogal, Sabogal, Perez-Stable, & Hiatt, 1995; Yi, 1998; Yu et al., 2002), which in turn prevent adequate knowledge about Korean immigrants' transitioning experience. Moreover, most studies fail to account for the multidimensional concepts of immigration transition and acculturation. Namely, a number of studies use one-dimensional scales or proxy non-scale measures to weigh the impact of acculturation on health outcomes (Kim, Lee, Ahn, Bowen, & Lee, 2007; Unger, Trinidad, Weiss, & Rohrbach, 2004; Yang, 2007). However, multidimensional approaches are more appropriate than one-dimensional methods for examining the transitioning of Korean immigrants (Jang et al., 2007; Lee et al., 2003). Additionally, despite the need for research that examines the impact of immigration transition on immigrants' health, comparison studies between Koreans in S. Korea and in the U.S. with cultural components are lacking (Jackson, Keel, & Lee, 2006; Kim et al., 2007; Sin, Choe, Kim, Chae, & Jeon, 2010; Song et al., 2004).

The impact of immigrant transition on the health and healthy lifestyles of Korean immigrants who have moved to the U.S. remains unclear. The studies reviewed provide insufficient detail on the researchers' methods (e.g., Kim et al., 2007; Unger et al., 2004;

Yang, 2007), and researchers report inconsistent findings when examining similar outcomes (e.g., Black & Markides, 1993; Otero-Sabogal et al., 1995; Yu et al., 2002). These problems with the literature imply a need for further research on health issues among Korean ethnic minorities. The proposed study explored the lifestyle and mental health context of Korean immigrants in the U.S. It will provide healthcare providers and researchers with additional knowledge about Korean immigrants' health and health needs as well as explain baseline differences in health issues between Koreans in the U.S. and those in S. Korea. It also will provide essential knowledge to initiate health care policies for immigrants. The findings from this study could provide useful cultural understanding of Korean immigrants for future studies.

Conceptual Framework

The middle-range theory of transitions (Meleis et al., 2000) was used as the theoretical framework to guide the investigation of the migration experience of Korean immigrants after resettlement to the U.S. Transition theory is appropriate to understand immigrants' lives or investigate struggles during immigration because this theory is relevant for any population who is experiencing any type of transition (Im, 2010). The major assumptions of transition theory are that transition has complex and multidimensional patterns and continually progresses as time passes (Im, 2010). During the process of transition, a person experiences various changes, such as identity, role, relationships, and behavioral patterns. Transition is defined as "passage from one life phase, condition, or status to another" (Chick & Meleis, 1986, p. 239).

The model of middle-range theory of transitions consists of three general dimensions of transitions: nature of transitions (types, patterns, and properties), transition conditions (personal, community, and society), and patterns of response (process and outcome indicators). Nursing therapeutics interconnects all three dimensions of the transition model and intervenes through nursing actions (Meleis et al., 2000).

The properties of transition experiences are interrelated, complex processes and include awareness, engagement, change and difference, transition time span, and critical points and events (Meleis et al., 2000). Concretely, awareness is connected to how the person perceives, knows, and recognizes a transition experience. Engagement is how much the person becomes involved in the process of transition. Changes and differences in the immigration transition are essential properties for understanding transitions. Transition changes identities, roles, relationships, abilities, self-identity, and patterns of behavior, and can lead to cultural conflict, mourning, marginalization, and role conflicts. Acculturation, which is the indicated level of psychological adjustment during the immigration transition, is one of the most common constructs in migration models and frameworks (Messias, 2002) and best described as a property of immigration transition. Acculturation is defined as a dynamic process that involves changes in immigrants' attitudes and behaviors and the adaptation to a new cultural environment from a person's original culture (Berry & Sam, 1997).

Transition conditions play important roles in mediating between transition properties and the indicators of healthy transition, which may facilitate or inhibit health transitions (Meleis et al., 2000). Individuals' self-control is a powerful and beneficial

adaptation (Tangney, Baumeister, & Boone, 2004), especially for immigrants who have relocated to a new country. To live healthier and happier lives, it is important for individuals to achieve an optimal fit to the environment (Tangney et al., 2004). Thus, to improve immigrants' adjustment to the new country and to increase their well-being, the condition of their sense of self is essential in the research field.

Families are considered the hub of healthy life and well-being, and how they function is crucial. Family functioning is how family members communicate, relate, maintain relationships, make decisions, and solve problems (Epstein, Bishop, Ryan, Miller, & Keitner, 1993). Despite the development of the Internet and communication technology, isolation from family or changes in family functioning in new situations may induce changes in the primary source of physical and psychological well-being. Healthy family functioning is defined as the capacity of "a family unit effectively coping with cultural, environmental, psychosocial, and socioeconomic stresses throughout the family life cycle" (David, 1978, p. 327).

Social resourcefulness needs are entities that are lacking but wanted or required to achieve a goal or attain a particular end (Dunst, Trivette, & Deal, 1988). Also, resource needs are an individual's judgment of the difference between his or her reality and what is considered to be desirable, normative, or valued from a help seeker's perspective (Dunst et al., 1988). Social functioning plays a significant role in an individual's well-being and how they cope with stress (Winefield, Winefield, & Tiggemann, 1992).

Indicators of a healthy migration transition include a sense of satisfaction, well-being, and mastery of skills and behaviors (Messias, 2010). Contentment or discontent

with prioritized aspects of lifestyle contributes to a person's sense of well-being (Becker, Diamond, & Sainfort, 1993). A person's sense of well-being may be an indicator of healthy transition. A healthy achievement of transition is determined by the extent to which individuals achieve obvious mastery of the skills and behaviors needed to cope with new situations and environments. Health promotion is defined as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health" (Tang, Beaglehole, & O'Byrne, 2005, p. 1). Health-promoting behavior refers to an individual's actions to maintain or improve health and wellness (Nursing Outcomes Classification, 2009).

The majority of previous studies of immigration have focused on predictions of poor health outcomes without understanding how transition to a new country affects specific populations of immigrants, which, according to transition theory, is an important influence on immigrant health. Also, to have a dynamic understanding of immigration transition, studies about multiple concepts of transition are needed because migration transition does not have a single domain but a multiple and complex domain structure, including transitions in language, culture, and social networks. Therefore, the purpose of this study was to explore the impact of immigrant transition on physical and mental well-being of first generation Koreans living in the U.S., using transition theory as a guide.

Research Questions

This study explored the impact of immigration transition on the health-promoting behaviors and mental well-being of Korean immigrants in the U.S. (Figure 1.1). Based on the research purpose and a review of the literature, the following specific aims and research questions (RQs) were explored:

Specific Aim 1*: Explore the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S. and S. Korea.*

RQ 1. What are the relationships between socio-demographic factors, immigration information factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S.?

RQ 2. What are the relationships between socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in S. Korea?

Specific Aim 2*: Explore the differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Koreans in the U.S. and in S. Korea.*

RQ 3. What are the differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Koreans in the U.S. and in S. Korea?

Specific Aim 3*: Identify the significant predictors of health-promoting behaviors and mental well-being for Koreans in the U.S. and in S. Korea.*

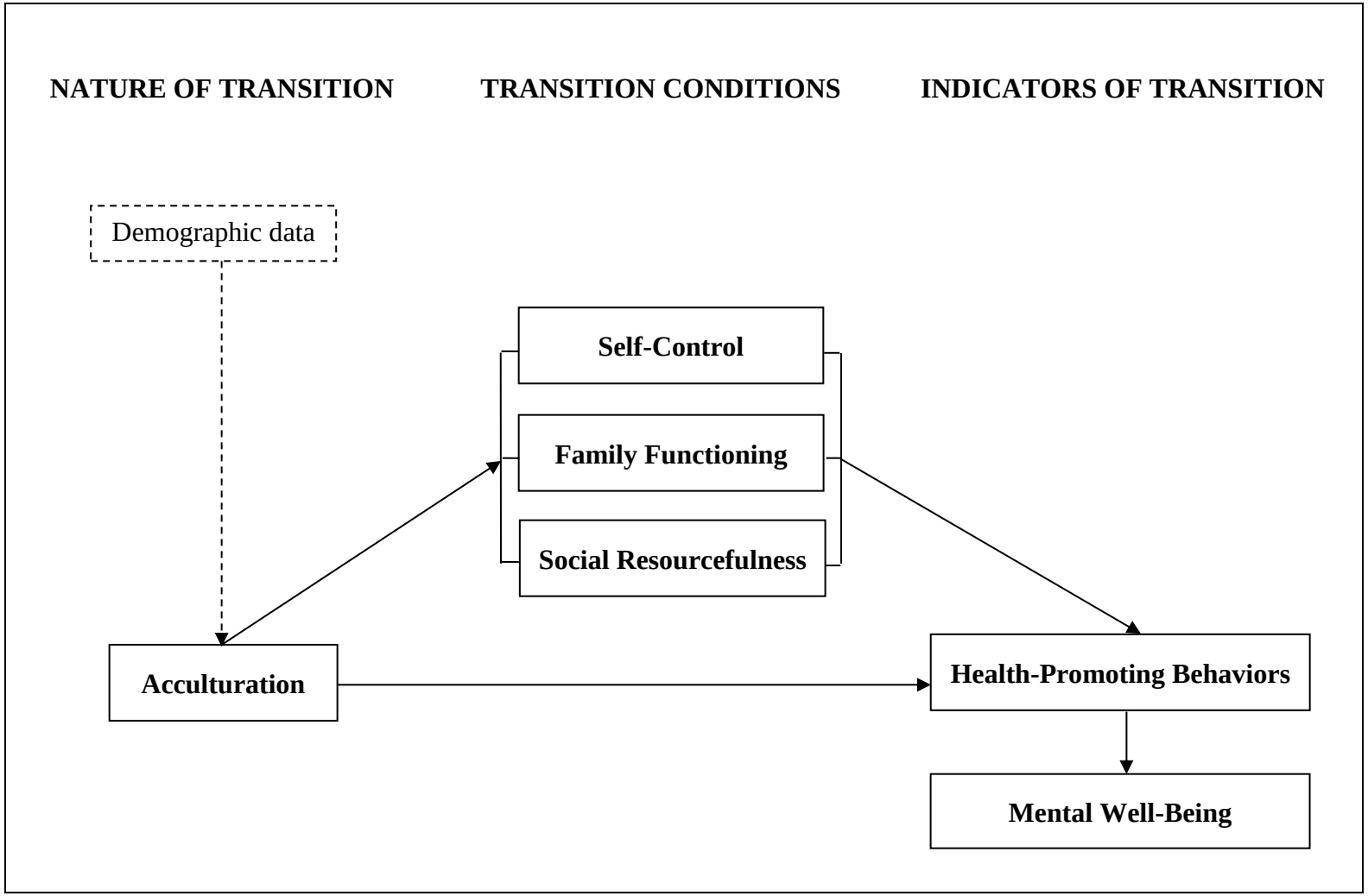
RQ 4. What are the predictors among socio-demographic factors, immigration information factors, acculturation, self-control, family functioning, and social resourcefulness of health-promoting behaviors and mental well-being for Koreans in the U.S.?

RQ 5. What are the predictors among socio-demographic factors, self-control, family functioning, and social resourcefulness of health-promoting behaviors and mental well-being for Koreans in S. Korea?

Specific Aim 4*: Determine mediating effects of self-control, family functioning, and social resourcefulness on the relationship between acculturation and health-promoting behaviors and mental well-being among Koreans in the U.S.*

RQ 6. Do self-control, family functioning, and social resourcefulness mediate the relationships of acculturation on health-promoting behaviors and mental well-being among Koreans in the U.S.?

Figure 1.1. Conceptual Framework for the Study Adapted from Transition Theory (Meleis et al., 2000)



Definitions of Terms

1st Generation Korean Immigrant

First generation Korean immigrants were born in Korea, and emigrated to and live in America as residents. It was measured by the answer to the item "Are you a 1st generation Korean immigrant?"

Transition

Transition is defined as "a passage from one life phase, condition, or status to another…transition refers to both the process and the outcome of complex person environment interactions" (Chick & Meleis, 1986, pp. 239-240).

Socio-demographic Characteristics

The socio-demographic characteristics describe the participants' background, which may influence acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being. They were measured by items in the socio-demographic question sheet, including age, gender, marital status, education level, employment status, perceived family income sufficiency, current health status, health insurance status, and living arrangements.

Immigration Characteristics

The immigration characteristics provide basic information about the immigrant population. The individual immigration characteristics that were measured were duration of residency in the U.S., age at arrival to the U.S., and English usage and proficiency.

Acculturation

Acculturation is defined as "the psychosocial adaptation of persons from their culture of origin to a new or host cultural environment" (Burnam, Hough, Karno, Escobar, & Telles, 1987, p. 90). The level of acculturation was determined by the total score on the Korean American Acculturation Scale (Lee, 2004).

Self-control

Self-control is defined as "a capacity to change and adapt the self so as to produce a better, more optimal fit between self and world" (Rothbaum, Weisz, & Snyder, 1982; Tangney et al., 2004, p. 275). Self-control was determined by the total score on the Self-Control Scale (Tangney et al., 2004).

Family Functioning

Family functioning is defined as "providing for the biological, psychological, and social development and maintenance of family members" (Steinhauer, Santa-Barbara, Skinner, 1984, p. 78). Family functioning was determined by the total score on the general functioning of the McMaster Family Assessment Device (Epstein et al., 1993).

Social Resourcefulness

Social resourcefulness is defined as "the behaviors, covert and overt, which an individual uses to establish and maintain supportive relationships" (Rapp, Shumaker, Schmidt, Naughton, & Anderson, 1998, p. 43). Social resourcefulness was determined by the total score on the Social Resourcefulness Scale (Rapp et al., 1998).

Health-Promoting Behaviors

Health promotion is defined by the World Health Organization as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health" (Tang et al., 2005, p. 1). Health-promoting behaviors are defined as "behaviors motivated by the desire to increase well-being and actualize human health potential" (Pender, Murdaugh, & Parsons, 2006, p. 7). Health-promoting behaviors were determined by the total score on the Personal Lifestyle Questionnaire (Muhlenkamp & Brown, 1983).

Mental Well-Being

According to the WHO (2011), mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." Mental well-being was determined by the total score on the Warwick-Edinburgh Mental Well-Being Scale (Tennant, Fishwick, Platt, Joseph, & Stewart-Brown, 2006).

Assumptions

Based on the conceptual framework and the review of literature, the following assumptions emerged:

1. Transition is a natural part of life (Chick & Meleis, 1986).
2. Immigration contributes to an individual's transition in beliefs and values about health and illness.
3. All participants honestly and accurately answered the survey.

Study Limitations

1. The generalizability of the study findings is limited because of the nature of a non-probability sample. This study may not reflect all possible participants with an accurate variety level of acculturation due to use of convenience and snowball sampling methods.
2. This design measures only a snapshot at one point in time with a cross-sectional design. The design of this study may induce different results in another timeframe. Also, this design may not reflect the dynamic impact of transition on immigrants' lifestyles.
3. The findings may reflect a response bias because people who were interested in the study topic or who have a close relationship with the investigator may have been more likely to participate.
4. Since the data was collected from a selected region in the U.S., the findings of this study may not reflect the situation of Korean immigrants in other areas of the U.S.
5. Self- administered questionnaires may result in misunderstanding or lack of understanding of the questions by respondents because the researcher and the respondent were not interacting (Mitchell & Jolley, 2012).
6. This study used acculturation to check level of transition; however, this measure may not capture all aspects of transitioning to the U.S.

Summary

This chapter introduces the topic of the study, including purpose, background and significance, conceptual framework, research questions, definitions, assumptions, and limitations, to highlight the need for the study of the transitioning experience of Korean immigrants through cultural concepts. The primary purpose of this study was to explore the influences of immigration transition on Koreans in the U.S.

This study was conducted to explore the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S. A similar assessment of S. Koreans was done also for descriptive comparison between the groups without an implied impact of the immigrant transition on the outcomes. The conceptual framework was based on the middle-range theory of transitions for immigrants (Meleis et al., 2000). The findings from this study could provide useful cultural understanding of Korean immigrants for future studies.

CHAPTER 2: REVIEW OF THE LITERATURE

This chapter reviews theoretical and empirical literature related to study purpose and conceptual background. First, this review includes the immigration history of Koreans to the U.S. and characteristics of Korean immigrants, as well as their traditional cultural values and beliefs. Second, the background of conceptual framework for this entire study, immigration transition, is reviewed, including U.S. immigrants and their health, as well as a literature review of immigration transition theory. Third, the major concept of this study, acculturation, is reviewed, including the relationships between acculturation and health behaviors and well-being in Korean immigrants. Last, concepts of transition conditions that emerged from the immigration transition theory are reviewed, including self-control, family functioning, and social resourcefulness.

Part 1. Korean Immigrants

Immigration History of Koreans to the U.S.

The immigration history of Korean Americans goes back over 100 years, since 1882 when diplomatic relations between Korea and the U.S. began (Kim, 2003). In 1884, the first travel between the countries occurred, with American missionaries going to Korea and a Korean moving to the U.S. Since the opening of immigration from Korea to America, Koreans have increased diversity in the American community. Historically, three distinct influxes of Korean immigrants occurred: the first wave during the early 1900s, the second wave during and after the Korean War, and the third wave after the passing of the Immigration and Nationality Act of 1965.

The first wave was from 1903 to 1905, when the first 120 Korean settlers came to Hawaii to work on sugar plantations because of economic, political, and religious turmoil in Korea. Over the next few years, the number of Koreans in Hawaii grew to over 7000. These first Korean settlers to Hawaii were motivated by economic opportunity. Many of these immigrants were young male laborers who lacked education and skills (Min, 2010). Hawaii and California were the major areas of settlement for Korean immigrants. However, this influx of Korean manual laborers stopped because Korea was attacked by Japan in 1905 (Min, 2010; National Association of Korean Americans [NAKA], 2003). After the annexation of Korea into Japan, the immigration of Koreans to the U.S. dramatically decreased until 1950.

After the Japanese colonization of Korea ended and with the outbreak of the Korean War in 1950, the second wave of Korean immigration, between 1950 and 1966, started primarily due to women who married American soldiers, Korean adoptees including war orphans, and sponsored students (Choy, 1979; Kim & Patterson, 1974; NAKA, 2003). The second wave of Korean immigration was stimulated by military, political, and economic connections between the U.S. and S. Korea (Min, 2006). The population characteristics were more diverse, with more women and children and a broader mix of skilled and unskilled laborers.

The third, largest wave of immigration to the U.S. in Korean immigration history began with the passing of the Immigration and Nationality Act of 1965. Koreans became one of the fastest growing Asian groups in the U.S. after Filipinos (Bonacich, Light, & Wong, 1977; Wong, 1982). Those who immigrated were motivated by educational

advantages for themselves and/or their children and invitations from family members who had already settled in the U.S. from previous waves of immigration (Hurh, 1998). Many of these immigrants were intelligent and skilled, such as students and professional workers who wanted more political stability, social security, and better educational opportunities for their children (Hurh, 1998; Shin & Shin, 1999). Over 95% of current Korean immigrants entered the U.S. after 1965 (Lee, 2012).

Since 1975, the Korean population has ranked in the top five Asian immigrant groups, following Chinese, Filipino, Asian Indian, and Vietnamese (Min, 2010). In the late 1980s, the number of Korean immigrants began to drop because of the improvements to Korea's economy and political stability and security. However, beginning in 2000, due to growing unemployment in Korea, the number of Korean immigrants to the U.S. has begun to increase again. Korean immigrants want to pursue better educational opportunities and career options for themselves and/or their children. According to the 2010 U.S. Census, the number of Korean Americans has increased by approximately 32% from 2000 to 2010.

Since the first influx of Korean immigrants to the U.S. in the early 1900s, the number of Korean immigrants in the U.S. has continuously grown, although the speed of Korean immigration has fluctuated between dramatic and steady increases.

Characteristics of Korean Immigrants

Numbering only 100,000 in 1970, the 2010 U.S. Census Bureau estimated the number of Koreans to be about 1.7 million, or nearly 10% of the U.S. Asian household population (U.S. Census, 2010). The Korean American community is the fifth largest

Asian subgroup in the U.S. after Chinese, Asian Indian, Filipino, and Vietnamese communities. These five ethnic groups accounted for about 81% of the Asian population, which is 3.4% of the U.S. total population. Although Korean immigrants have a relatively short immigration history, Koreans are one of the fastest growing subgroups of the U.S. immigrant population.

Korean Americans were previously categorized as part of a homogeneous group in the national statistical data, but since the 2000 U.S. Census, Koreans could identify as "Korean alone" or "Korean in any combination" for Koreans and any other ethnic combination. Although the percentage of multiracial Korean families in the U.S. varies greatly by state, this trend has steadily increased in all regions. The highest number and proportion of multiracial Korean Americans is in Hawaii. Harvey and Chung (1980) reported that from 1960 to 1968 nearly 80% of Korean brides and grooms in Hawaii were married to non-Korean partners. The proportion of mixed race Koreans in Hawaii has reached 43%. Also, in recent years, this multiracial trend in the Korean ethnic group brings additional diversity to the Korean American community because of Korean Mexicans and Korean Brazilians who have immigrated to the U.S. According to the 2010 U.S. Census, 14.5% of the Korean population is combined with other Asians, and 28.6% is combined with other races.

Among Asian groups in 2010, Koreans had the lowest proportion of U.S. born Americans with about 24%, compared to Japanese who had about 58%. This is an increase compared to the 16.3% of Koreans who were U.S. born in 1980 (Asian American Studies Program [AASP], 2011; U.S. Census, 2010). Korean Americans are

still predominantly foreign-born; three out of four Korean Americans (76%) were foreign-born. Among foreign-born Korean immigrants, over 95% were born in Korea (AASP, 2011).

Most Asian American subgroups tend to settle in or near large cities within their own ethnic communities and tend to maintain their ethnic identity. Korean Americans are highly concentrated in the western U.S. The five states with the largest estimated Korean American populations are California (29.6%), New York (9.0%), New Jersey (5.9%), Texas (5.0%), and Virginia (4.8%) (U.S. Census, 2010). Historically, Korean Americans initially settled in Hawaii and California and developed from these regions; however, recently Korean Americans are dispersed in almost all regions of the U.S. Korean Americans historically showed a tendency to concentrate in large metropolitan areas. Nearly 95% of Korean Americans settled in metropolitan areas (Min, 2006). According to the 2010 U.S. Census, nearly 57% of Korean Americans reside in ten major cities: Los Angeles, New York, Washington D.C., Seattle, Chicago, San Francisco, Atlanta, Honolulu, Philadelphia, and Dallas. However, this proportion decreased from about 70% in 2000, which is evidence of the geographic dispersal of the Korean population to further regions of the U.S.

Korean Americans show a higher level of educational attainment; 50.8% of Korean Americans hold college degrees or above compared with 27.3% of the general population in the U.S. (AASP, 2011). Although they are highly educated, about 50% of Koreans aged 5 and older speak non-English at home and speak English less than very well (U.S. Census, 2010). Among the first generation, only 12.6% report that they speak

English fluently (AASP, 2011). Approximately 17% of Korean Americans are first generation immigrants who were fully educated outside of the U.S. and immigrated at age 35 or older. About 60% are 1.5 generation Korean Americans who were born outside of the U.S , at least partially educated in the U.S., and immigrated at age 34 or younger (AASP, 2011). The majority (55.7%) of foreign-born Koreans entered the U.S. prior to 1990. About 28% of foreign-born Koreans entered during the 1990s and about 17% arrived in 2000 or later.

Koreans have achieved economic growth within a short period of U.S. immigration history. However, Korean Americans showed the biggest bi-diversity in wealth in the U.S.; they were some of the wealthiest and poorest of all Americans in 2010 (AASP, 2011). The average median household income of Korean Americans was $60,000, which is considerably higher than the average median of $51,800 for the general U.S. population. The unemployment of Korean Americans was 6.8% in the aged 18-64 labor force, which is lower than the 9.2% of the general population. However, with 14% at the poverty level, Korean Americans' poverty rate is higher than that of the non-Hispanic White population (8%) and other Asian Americans (10%) and even higher than the 12.6% of the general population. Another noticeable economic characteristic of Korean immigrants in the U.S. is the high proportion engaged in small businesses such as dry cleaners, nail salons, and liquor stores. Over half of Korean immigrants (58%) are engaged in self-employed small businesses compared to a much lower percentage of Chinese (18%) and Mexican (9%) immigrants in the U.S. (Lopez- Garza & Diaz, 2001).

Korean Cultural Values and Beliefs

Korean Americans have one of the strongest attachments to the values and practices of their original culture in the U.S., although ethnic combinations have been recently increasing (Jackson, 2006). Most Korean Americans are able to speak some Korean and engage in Korean cultural practices such as eating mostly Korean food. Thus, Koreans often share common knowledge, beliefs, and attitudes about health and illness.

This homogeneity stems from Korean Americans' strong ethnic attachment and collectivism (Min, 2006). Korean Americans often share common knowledge, beliefs, and attitudes related to health behaviors and well-being within their ethnic enclaves and not with other ethnicities or the mainstream population (Lee, 2012).

The primary underpinning of traditional Korean cultural and social values is based on Confucianism (Oak & Martin, 2000). Ancient Confucianism refers to the teachings of Confucius from 551 to 479 B.C. and those of his followers. After the fourth century, when Confucianism was first introduced to Korea from China, Confucianism had begun to spread gradually and has influenced the entire culture of Korea for centuries (Peterson, 1997).

The principal teachings of Confucianism emphasize the importance of mercy, social order, and fulfillment of responsibilities in achieving harmony, which is the most significant social value. It is a system of behaviours and ethics that stresses the obligations of people toward one another based upon their hierarchical relationship. The teachings of Confucius stress the five relationships of the individual; sovereign-subject, father-son, elder-younger brother, husband-wife, and friend-friend. Three of the five

primary relationships are familial, and family is one of the most important social structures in Confucianism as well as in Korea. The family's needs and interests are much more important than the needs of the individual. Members of the family are tied to each other because the actions of one family member reflect on the rest of the family.

Another underpinning of Korean traditional cultural and social values is collectivism (Oak & Martin, 2000). The most distinctive characteristic between collectivism and individualism is how tightly bound individuals are to society (Cha, 2010). In collectivism, individuals are tightly connected to their in-groups whereas in individualism, individuals have a looser bond with their community. Thus, collectivistic cultural values emphasize group goals above individual goals, while individualistic cultural values emphasize individual goals more than group goals. Individualism and collectivism are some of the most disparate values between Western and Asian cultures (Markus & Kitayama, 1991; Singelis, 1994; Singelis & Brown, 1995). According to collectivism, when individual values conflict with the needs of the group, the needs and values of the group are first, although the individual endures a personal loss. Also, in collectivistic values, people connect more deeply than broadly with others, and gather tightly in groups while keeping a distance with outside groups.

Due to relative ethnic homogeneity, Korean collectivism is distinguished above other Asian groups (Rhee, Uleman, & Lee, 1996). In collectivism in Korea, an individual's values are based on the values of groups they belong to, not a value of the self, because individuals are not separated from the group. Thus, individuals inside groups are identified with their groups, and this connection leads to a sense of collective

'we'ness, a sense of oneness, sameness, and strong ties to a group (Choi & Choi, 2002; Farver, Kim, & Lee-Shin, 2000). The family is the basic unit of social structure. Individuals in collectivism perceive themselves as a part of 'we.' The bounds of 'we' are not limited, and can refer generally to a family, their engaged school, company, community, and more broadly their ethnic group varying by situation.

Korean Americans have several unique characteristics due to strong attachment to Korean cultural values (Jackson, 2006). Korean Americans tend to gather at Korean churches. Korean churches function as a place for meeting other Korean immigrants and maintaining social ties to Korean culture. For example, most Korean churches have education programs to teach formally or informally the Korean language to 1.5 or 2nd generation children. Also, Korean Americans tend to gather at Korean businesses, which provide Korean supplies as well as recent trends from the homeland, Korea. Korean churches and businesses are major mediums for Korean immigrants to maintain social interactions with other Koreans as well as ethnic ties to Korean culture. Thus, based on the traditional values which broadly extend to Koreans, such as Confucianism and collectivism, family-centered and group-based approaches within Korean communities are needed to understand individuals' well-being.

Summary of Part 1: Korean Immigrants

The immigration history of Koreans to the U.S. is relatively brief and has had multiple waves. The number of Koreans has increased and this population has dispersed all over the U.S. Koreans have a unique culture, which originates from Confucianism and collectivism. Koreans' cultural values affect the concept of the self and family as well as

overarching social structures. They have moved their physical environments to the U.S., but their traditional culture remains in their lives.

Although Korean immigrants are a quickly growing minority group in the U.S., studies on this population are limited. Korean Americans are often excluded from research studies, or treated homogenously with Asian or Asian and Pacific Islanders. To understand Korean immigrants' beliefs and values regarding health and illness, perspectives regarding Koreans' tranditional culture and historical background are required.

Part 2 Immigration Transition

Immigration Transition in the U.S.

Transition is a process that takes place over time and includes flow and movement (Meleis & Trangenstein, 1994). Transnational migration is characterized by "multidirectional flow and movement of persons … across host and home societies" (Messias, 2010, p. 226). Immigration transition is "a complex situational transition that rarely occurs in isolation" (Messias, 2010, p. 228). An individual's immigration transition is affected by social, cultural, economic, and environmental changes. Transnational migration is a comprehensive and multidimensional transitional change. A complex situational transition, migration may lead to primary social, cultural, economic, and environmental changes, as well as potential development through far reaching human interactions and social networks (Jones, Zhang, & Meleis, 2003; Meleis et al., 2000).

In the multidimensional and multidirectional transition of immigrants, the concept of culture in health research plays a pivotal role as a major predictor of health status, which has garnered the interest of a broad cross-section of health researchers and healthcare providers. During immigration transition, individuals discard some of their original beliefs and values and accept or modify their values to fit into the host country. Thus, immigration is a fundamental cultural transition that may influence changes in health and health-related behaviors of immigrants as well as their families' health.

The international immigration experience can affect the health of both immigrants and the host country, making understanding the effects of the immigration transition internationally relevant. Various researchers describe immigrants as one of the most

vulnerable groups of healthcare consumers due to their experiences with major environmental, social, and economic changes while confronting unfamiliar healthcare systems (Barr, 2008; Kulwicki, Miller, & Schim, 2000; Meleis, 1991).

Immigration has been a major source of general population growth throughout U.S. history. Between 1990 and 2010, while the U.S. total population changed from roughly 250 million to 310 million, the number of immigrants to the U.S. doubled from 20 million to 40 million (U.S. Census, 2010). One third of U.S. population growth has been influenced by immigration directly, and half of U.S. population growth has been impacted by second- and third- generation immigrants. The majority of new immigrants are originating from Central/South America and Asia. According to the 2009 data, 42% of immigrants came from Central/South America, 37% from Asia, and 11% from Africa (Mora, 2011). From 2000 to 2010, approximately 14 million immigrants from various countries have entered the U.S.

Since the first settlers from Britain arrived in 1620, the diversity and number of immigrants to the U.S. has steadily increased (Kyoso, 2010). Immigrants come from all over the world through both illegal and legal channels. However, immigration is considered one of the most significant and stressful life events in an individual's whole lifespan. Regardless of whether immigration is voluntary or involuntary, immigrants suddenly experience changes in many aspects of individual life (e.g., socioeconomic status, social networks, and family structure and function) within a short period of time and during the subsequent adaptation process (Shin, Han, & Kim, 2007). Immediately after immigration, immigrants showed better health than U.S. born populations because

many immigrants have healthier lifestyles before immigrating to the U.S. They may also have more extensive social support than U.S. born populations. Immigrants also undergo a health screening to adhere to immigration policy (Goel, McCarthy, Phillips, & Wee, 2004; Jasso, Massey, Rosenzweig, & Smith, 2005; Singh & Hiatt, 2006).

Despite these good starts, immigrants are one of the more vulnerable populations, and their health is impacted by sociocultural and environmental changes and stress. Immigrants' vulnerability in health is indicated by the lack of health insurance, difficulty in finding a regular source of care, and lower access to healthcare (Derose et al., 2007; Dey & Lucas, 2006; Huang et al., 2006; Lucas, Barr-Anderson, & Kington, 2003; Singh & Hiatt, 2006). It can also be compounded by limited English proficiency and stigma and marginalization based on cultural and religious practices, specific accents, and differences in appearance (Derose et al., 2007). Immigrants and those who have limited English proficiency are less satisfied with and feel more discrimination from healthcare service providers than U.S. born or English-speaking populations (Derose et al., 2007). The health of immigrants also deteriorates from the stress of the immigration process (Alderete et al., 2000; Cunningham, Ruben, & Narayan, 2008; Jasso et al., 2005; Sundquist & Winkleby, 2000), and harmful working and living environments induced by poor employment status (Cunningham et al., 2008; Holmes, 2006; Sandhaus, 1998).

Although Korean immigrants have relatively high education levels (AASP, 2011; Kuo & Porter, 1998), Korean immigrants face challenges relating to socioeconomic status and language differences in navigating the healthcare system (Yang, 2007). When compared to the 9.2% of other Asian immigrant groups and 8.9% of non-Hispanic whites

who report fair or poor health, 13% of Korean immigrants report fair or poor level of health (Kuo & Porter, 1998).

To understand immigrants' lives or investigate their struggles during transition, transition theory is appropriate and relevant for any population who is experiencing any type of transition (Im, 2010). Also, in order to improve the health of immigrants integrating into the mainstream society of the host country, it is important to examine immigrants' transition process into the new country.

Transition Theory for Immigrants

A review of the literature that used the middle range theory of transition and focused on immigrants and refugees examined ten studies published since 2000 (Table 2.1). Although all collected studies examined the experience of immigrants, the main focus of each study varies; four studies focused on immigrants' experiences during transition (Baird, 2009; Jadalla, 2007; Larson & McQuiston, 2008; Messias, 2002), two studies on immigrants' developmental transition (Im & Meleis, 1999a; Jones et al., 2003), one study on immigrants' situational relocation transition (Almendarez, 2007), and one study on immigrants' health/illness transition (McEwen, Baird, Pasvogel, & Gallegos, 2007). Two studies explored immigrants' attitudes/experience toward specific situations, including physical activity and elderly parents' care (Im & Choe, 2001; Lindgren, 2004).

Four studies on immigrants' experiences during transition were explored with a variety of perspectives (Baird, 2009; Jadalla, 2007; Larson & McQuiston, 2008; Messias, 2002). Baird's study using ethnography with in-depth interviews (2009) examined the resettlement experiences and influences on health and well-being of Sudanese refugee

women. The transition experience of refugee women is explained through understanding the relationships between three themes: living between two cultures, standing for oneself, and hope for the future. These three linked themes lead to their well-being in the U.S., which was a process that evolved over the time of their resettlement. Jadalla's study (2007) explored the relationships between acculturation, health, and health behaviors in adult Arab Americans. Arab American adults reported better physical health and worse mental health status than the published averages of the U.S. population. Physical health was related to demographic factors rather than acculturation in Arab Americans. Mental health was more attributed to the American culture; however, health-promoting behaviors were more attributed to both American and Arabic cultures. In Larson and McQuiston's (2008) study that used focus group interviews to explore the relationship between acculturation and perceived health concerns with gender specific perspectives, early Latino adolescents reported gender differences in health concerns, language gender variation, and the importance of family health as a health concern. Girls expressed health concerns about unsolicited physical contact and aggressive male behavior while boys expressed health concerns about stress due to financial worries and drinking alcohol. Messias (2002) examined immigrant women's transnational experiences and Brazilian women's health concerns using a narrative interpretive study with a feminist perspective. Brazilian women reported that immigrants relied on a combination of personal and collective transnational resources for their health. This reliance discouraged them from seeking formal healthcare. Also, immigrants moved back and forth across informal and formal healthcare systems, crossing multiple national, cultural, and healthcare system

borders for health and illness concerns. Messias referred to immigration as transnational transition, which is dynamic, multidirectional movement.

Two studies examined immigrants' developmental transition (Im & Meleis, 1999a; Jones et al., 2003). Im and Meleis (1999a) extended transition theory to a situation-specific theory of Korean immigrant women's menopausal transition using qualitative and quantitative methodological triangulation. Three themes were reported in first-generation Korean immigrant women. The women gave their menopausal transition far less attention than they did their immigrant and work transition. Additionally, menopause was a hidden experience in their cultural background. Finally, the women "normalized," ignored, and endured menopausal symptoms. This study identified that immigrant and work transitions in Korean immigrant women were more difficult to overcome than menopausal transition. The patriarchal cultural background of these immigrants created a code of silence in regard to female developmental issues. Ultimately this caused the women to minimize their experience of menopausal transition, ignoring the symptoms and enduring them without discussion. Jones, Zhang, and Meleis (2003) used grounded theory to examine role transition for caring for older parents of Chinese and Filipino immigrant women. These women experienced a conflict between traditional culture and new culture in serving the role of caring for elderly parents. The women expressed desire to be loyal to their traditional culture and maintain strong filial values during transition. The women mobilized personal and family resources to transform vulnerability into strength and well-being. Most immigrant women reported increased well-being, and a

sense of growth and higher education and economic status buffered the immigration stress.

Almendarez (2007) examined immigrants' situational relocation transition. This study explored subjective perceptions of factors influencing Mexican American dyads (elders and their families) during the process of transition from independent living to nursing homes. This study reported the complex types of transition in the nursing home transition: health-illness and situational immigration transition. The major themes that emerged from the interviews were families, "respeto," acculturation, and acculturative stress in concepts of cultural beliefs and attitudes.

One study examined immigrants' health-illness transition (McEwen et al., 2007). McEwen, Baird, Pasvogel, and Gallegos (2007) conducted an intervention study of the health-illness transition of Mexican immigrant women with type 2 diabetes. This study explored the potential effect of diabetes education and social support intervention on the health-illness transition. It was found that intervention with the following cultural aspects was effective in healthy transition: diabetes knowledge, self-efficacy, and psychosocial and health-related behavior problems. The transition experience of Mexican women is explained with three themes: difficulty in acknowledging diabetes as part of one's life, adjusting to change and difference, and putting family first, which are addressed in the transition model.

The next two studies focused on immigrants' attitudes and experiences toward specific situations. Im and Choe's study (2001) examined Korean immigrant women's need for and attitude toward physical activity. Korean women's attitudes toward physical

activity reflected their cultural background and lives as Korean immigrant women. Korean culture influenced women's view of their own body, healthcare, and their daily lives in terms of physical activity. Lindgren (2004) investigated community participation among Afghan refugee women and identified related individual and community changes using ethnography. This study found that history and culture of home country influenced Afghan women's lifestyles and their community participation. The women have increased knowledge, skills, and participatory strategies and impacted the community through the creation of community organizations. Three themes in Afghan immigrants' cultural transitions were revealed: gendered role and adjustment patterns, changing family dynamics, and generational conflicts.

Transition theory has been produced by a literature review and existing research findings. Several situation-specific theories result from transition theory (Im, 2006; Im & Meleis, 1999b; Schumacher, Jones, & Meleis, 1999). Transition theory makes it easier to explain the health-illness transition as well as immigration transition, and improves the understanding of the immigrants. In this literature review about immigrants and refugees, the relationships between migration transition and other transitions (e.g., health-illness transition or developmental transition) are not revealed. McEwen and collegues (2007) explained health-illness transition experience among immigrants who experienced migration transition rather than the relationship between health-illness transition and migration transition. Im and Meleis (1999) mentioned that migration transition was more focused than women's developmental transition (menopause) among Korean immigrants.

Transition theory helps researchers understand transition experiences and provides new perspectives for researchers to study.

Summary of Part 2: Immigration Transition

Throughout U.S. history, immigration has been a significant contributor to general population growth. Immigration transition is a global phenomenon with radical social, cultural, economic, and environmental implications, and can be both disruptive as well as life enhancing for individuals.

To better understand the changes and challenges immigrants experience during their immigration transition, transition theory should be used because it is applicable for Korean immigrants experiencing immigration transition. Also, in order to improve the health of immigrants integrating into the mainstream society of the host country, it is important to examine immigrants' transition process into the new country. Cultural adjustment caused by immigration transition may involve changes in behaviors, beliefs, and values of individuals or groups. Cultural adjustment in immigrants is very important for achieving desired health outcomes and health-related behaviors. The review of literature examined transition theory for immigrants.

Table 2.1. Synthesizing Research for Using Transition Theory for Immigrants

Authors	Purpose	Design	Population	Instruments	Major Findings
Almendarez (2007)	To explore subjective perceptions of factors during the process of transition from independent living to nursing homes	Ethnography	10 Mexican American dyads (elderly/family member)	Semi-structured interviews	Participants reported two types of transitions: situational and health/illness-related. Most transition patterns were multiple and/or sequential.
Baird (2009)	To understand the resettlement experiences	Ethnography	10 southern Sudanese refugee women	In-depth interviews and observation	Well-being in Dinka mothers is understood through the relationships between three major themes: living between two cultures, standing for oneself, and hope for the future.
Im & Choe (2000)	To explore women's own needs for and attitudes toward physical activity	Methodological triangulation	Quantitative: 54, Qualitative: 16 Korean immigrant women	Semi-structured interviews; Measurement scale of needs for physical activity	Korean immigrant women's needs for and attitudes toward physical activity were influenced by the contexts of their culture and immigration, and deeply associated with the women's daily experiences
Im & Meleis (1999)	To extend the previous model of transitions during menopausal transition	Methodological triangulation	119 first-generation Koran immigrant women		Koran women extended the model of transitions by including the experiences during menopausal transition.

Table 2.1. cont'

Authors	Purpose	Design	Population	Instruments	Major Findings
Jadalla (2007)	To explore the relationships between acculturation, perceived discrimination, health, and health behaviors	Descriptive correlational study	297 adult Arab Americans	DHDS[1]; PD[2]; CMAS[3]; HPLP-II[4]; RAND-36; ARSAA-II[5]	Arab American adults reported better physical and worse mental health status than the published norms of the U.S. population.
Jones, Zhang, & Meleis (2003)	To examine the caring experience for older parents	Quantitative/ Qualitative	41 women (22 Chinese, 19 Filipino American)	Acculturation scale; In-depth, semi-structured interviews	The women expressed desire to be loyal to their traditional culture and maintain strong filial values during transition. The women mobilized personal and family resources to transform vulnerability into strength and well-being.
Larson & McQuiston (2008)	To explore the relationship between acculturation and perceived health concerns	Qualitative descriptive	26 early Latino adolescents (14 girls, 12 boys)	Semi-structured interviews	Three themes were reported: gender differences in adolescent health concerns, gender variation in language based on context, and the importance of family health.

[1]Demographic and Health data survey; [2]Perceived discrimination ; [3]Cultural maintenance and adaption scale; [4]Health-promoting lifestyle profile II; [5]Acculturating rating scale of Arab Americans II

Table 2.1. cont'

Authors	Purpose	Design	Population	Instruments	Major Findings
Lindgren (2004)	To examine community participation and to identify related individual and community changes	Ethnography	19 Afghan refugee women, residing in the San Francisco Bay area	Semi-structured interviews	Participants have increased knowledge, skills and participatory strategies, and impacted the community through the creation of community organizations.
McEwen, Baird, Pasvogel, & Gallegos (2007)	To explore the potential effect of the intervention on the health-illness transition	Mixed; Quantitative/ Qualitative	15 Mexican immigrant women with type 2 diabetes	DKQ[6], MOS[7], Self-efficacy for Diabetes Scale; Semi-structured interview	Participants increased significantly from pre- to post-intervention in diabetes knowledge and diabetes self-efficacy, and decreased significantly in psychosocial and health-related behavior problems.
Messias (2002)	To examine transnational health perspectives, practices, and resources	Qualitative: feminist narrative interpretive	26 Brazilian women	In-depth interview	In taking care of health, immigrants relied on a combination of personal and collective transnational resources. In responding to health and illness concerns, immigrants moved back and forth across informal and formal health care systems, crossing multiple national, cultural, and health care system borders.

[6]Diabetes Knowledge Questionnaire; [7]Medical Outcomes Study

Part 3. Acculturation

Conceptual View of Acculturation in Present Study

Cultural transition is inevitable for everyone, but for immigrants who settle in a new country, the cultural changes are especially significant. An individual's beliefs and values about health and illness are influenced by culture, which in turn contributes to health-related behaviors and choices, as well as general health status. Tylor (1871) defines culture as a society's common knowledge, values, art, ethics, laws, and traditions. A group's culture is developed through common language, socialization, customs, and values (Gollnick & Chinn, 2006; Rohner, 1984). Thus, individuals can learn different cultural beliefs and values, and that culture changes are not static (Gollnick & Chinn, 2006).

Acculturation is commonly operationalized to represent the ethnic cultural transition for individual immigrants. Social and behavioral researchers and anthropologists developed the concept of acculturation (Chun, Organista, & Marin, 2003). Acculturation is defined as "the process of an individual's interaction with the mainstream culture" (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). Redfield, Linton, and Herskovits defined acculturation as "those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (1936, p. 149). Thus, changes in attitudes, values, and behavioral norms occur over time with contacting other cultures (Berry, 1980).

Acculturation is accompanied by changes in all levels of social, psychological, and cultural aspects of immigrants' lives and results in changes to their attitudes, beliefs, and behaviors (Berry & Sam, 1997). Acculturation is not simply assimilating into the host culture, but involves acquiring new attitudes and behaviors from the host culture, while retaining preferred aspects of original cultures (Cuellar, Arnold, & Maldonado, 1995; Looner & Berry, 1986). Thus, acculturation is a transition which can facilitate or inhibit personal development. Also, acculturation involves both cultural groups: the host and sending countries and individuals. Although one culture is usually dominant over the other, adaptation to living together in society is followed by reciprocal accommodation between the groups and individuals.

Acculturation is characterized by a bidirectional adjustment process rather than unidirectional process of change (Berry, 1980; Mendoza & Martinez, 1981; Sodowsky, Lai, & Plake, 1991; Teske, & Nelson, 1976). One direction is the assimilation to the mainstream culture and the other is the retention of the ethnic culture. Thus, immigrants may confront two different situations: the desire for maintaining and developing their own ethnic distinctiveness in society and another desire for inter-ethnic contact (Berry, 1980).

Individual ethnic groups show significantly different levels of attachment to the mainstream culture and their culture of origin in functioning within new cultural environments (Padilla, 1980). The acculturation style varies among individuals with different sociocultural and demographic variables including education level, income, age at entry into the U.S., and family size. Individuals may negotiate between the original

country and new country in cultural contexts such as values, customs, and practices (Berry, 1980; Berry, Poortinga, Segall, & Dasen, 1992).

Acculturation and Health in Korean Immigrants

The increasing significance of Korean American immigrants necessitates closer assessment to better understand their lifestyle practices and the health consequences their lifestyles may produce. To adjust to a new culture and modify their original values when they relocate to a new country, immigrant individuals encounter many challenges that involve extreme lifestyle changes and adaptation stress to a new culture (Organista, Organista, & Kurasaki, 2003). Focusing on immigrants' integration in the host country, the concept of acculturation was adapted by multidisciplinary researchers. Healthcare providers as well as researchers have also struggled to gain knowledge of the effect of acculturation on immigrants' health and health-related behaviors. Although acculturation is well-known and generally recognized as a measurable variable, studies that use acculturation as a variable disproportionately focus on Hispanic or Latino populations and a broad variety of health concerns for this group while ignoring other ethnic groups (Myers & Rodriguez, 2003; Organista et al., 2003).

Perceived physical health status was positively associated with acculturation; that is, high levels of acculturation were significantly related to better overall health among Korean Americans, including the elderly and women (Chong, 2009; Kim, 2002; Shin, 2011). The positive evidence was more closely associated with physical health, general activity, westernized diet patterns, oral contraceptives use, and Alzheimer's disease knowledge. A positive relationship with American society was related to better physical

health status, since good adaptation to a new society reduces stress (Ayers et al., 2009; Oh, Koeske, & Sales, 2002). Diverse studies with different populations found the same result of a positive relationship between acculturation and self-reported health status (Gonzáles, Tarraf, & Haan, 2011; Johnson, Carroll, Fulda, Cardarelli, & Cardarelli, 2010; Wiking, Johansson, & Sundquist, 2004).

The studies of the existing literature on acculturation of Korean immigrants have some issues. Several studies lacked the necessary definitions of their cultural concepts, and the authors assumed that readers would use their knowledge base as a frame of reference (Jang et al., 2007; Lee et al., 2000, 2003). There was a lack of clear definitions and an inconsistent use of definitions surrounding the concept of acculturation in the literature on Korean Americans. Many studies that examined acculturation did not mention the definitions or concepts of acculturation in which the study was based (e.g., Kim et al., 2005; Lee et al., 2004; Shin et al., 2005). Instead, authors assumed the readers had common knowledge of what acculturation means. The half that defined acculturation were vague in both the content and application of the definitions they mentioned. For example, researchers who used Berry's definition, which states that acculturation is a multidimensional process, were inconsistent with Berry's theoretical definition and their operational definition used one or more proxy measurements.

This intentional or unintentional omission may stem from the overwhelming number of studies related to immigrants and cultural components and be unavoidable due to limited pages in journals. This is, however, a common problem in research on acculturation, which was found in other literature reviews on immigrants' acculturation

(Hunt, Schneider, & Comer, 2004; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Salant & Lauderdale, 2003).

Although cultural changes have multifarious components, acculturation studies on Korean Americans used proxy non-scale measures or uni-dimensional scales. Also, the theoretical underpinnings of scales were not explicitly noted. Many studies used only non-scale based measures or only one item as a measurement (e.g., Kim et al., 2007; Unger et al., 2004; Yang, 2007). Also, studies using proxy measures did not mention the theoretical underpinnings, the scale's reliability and validity, or the scale's origin. Few studies stated the theoretical foundation for their acculturation scales (e.g., Lee, Lee, & Diwan, 2010; Park, Paik, Skinner, Ok, & Spindler, 2003; Sohn & Harada, 2005). A critique of using one-dimensional measurements for examining the impact of acculturation on immigrant populations was discussed in an earlier publication (Rogler, Cortes, & Malgady, 1991). Even two decades later, linear and uni-dimensional measurements are still being used despite many authors' suggestions that multidirectional scales are more appropriate than single-continuum or unidirectional scales for examining the acculturation of Korean Americans (Jang et al., 2007; Lee et al., 2000, 2003).

Another issue in existing literature is unpredictability in the measures of acculturation to Korean Americans (Chen et al., 2011; Unger et al., 2004). A lack of methodological consistency might contribute to mixed and confusing results (Lara et al., 2005). The concept of culture is a unique and distinctive component of an ethnic group; however, in this literature review, the majority of studies used scale-based measures originally designed for use with other ethnic groups. In examining the scales, only a few

words were changed prior to administering the revised scale to Korean populations, which was not consistent with the literature describing unique aspects of acculturation for Koreans. Although acculturation may have trans-cultural components that may be measured using similar assessment tools, the questions must be tailored to the ethnic group of interest.

The most popular assessment tools for acculturation, the Suinn-Lew Asian Self-Identity Acculturation scale (SL-ASIA) (Suinn et al., 1987), were based on tools originally developed for examining the level of acculturation of Mexican American populations, the Acculturation Rating Scale for Mexican Americans (ARSMA) (Cuellar, Harris, & Jasso 1980). Some developed scales focused on multiple cultures instead of individual ethnic groups; for example, the Vancouver Index of Acculturation (VIA) defined North American as the host group and all ethnic minorities were grouped together as native cultures or heritages (Ryder, Alden, & Paulhus, 2000). Another example was the Asian American Multidimensional Acculturation Scale (AAMAS) which included a pan-ethnic Asian American dimension, and was used across ethnic groups (Chung, Kim, & Abreu, 2004). The Acculturation Attitudes Scale (AAS) (Kim, 1988) was originally developed to study Korean Canadians. Only one study used a scale originally developed for Korean Americans, the Korean American Acculturation Scale (KAAS) (Lee, 2004). The KAAS includes acculturation characteristics and patterns of Korean Americans, such as cultural and behavioral domains.

The number of studies on any one aspect of health outcomes research was limited. There were several studies, but the focus of the work was conceptually broad with mixed

outcomes. The number of studies on specific relevant variables was small; some variables were treated only by a single study, such as the effect of acculturation on healthcare use, women's oral contraceptive use, and social support. The earliest publication on acculturation of Korean Americans found through this reviewing process was published in 1994 (Shin, 1994), which reflects the short history of studies on immigration of Korean Americans. Although using non-scale measures (individually or in combination) may increase the efficiency of exploring the health effects of separate dimensions of acculturation, the studies may not reflect the multi-directional nature of acculturation.

The effect of acculturation on health outcomes and health-related behaviors is complicated and confounding. The relationship of acculturation to each separate variable was not always the same, with some variables, like marital status and alcohol consumption, demonstrating opposite results in different studies. These inconsistent findings may be due to variations in measurement. The insufficient number of studies may lead to hasty generalizations about Korean immigrants' transitioning experience. Lack of appropriate measurements for Korean Americans may bring inconsistent findings and mislead researchers about Korean immigrants' health and health behaviors.

To seek a better understanding of acculturation-related health outcomes and lifestyles and how Korean immigrants respond to their new culture, the concepts of acculturation must be examined in many research studies of Korean immigrants.

Acculturation and demographic characteristics in Korean immigrants.

The majority of studies that examined the relationship between acculturation and Korean immigrants' demographic characteristics used length of stay in the host country

as a demographic variable. Other variables included current age, age at arrival to the U.S., education level, income, gender, marital status, health insurance status, and the number of people in a household. Overall, the relationships between demographic variables and acculturation were mixed and not well documented.

A majority of studies that mentioned the level of acculturation of targeted individuals of Korean descent reported that this population was less or moderately acculturated (Choi & Rankin, 2009; Jasti, Lee, & Doak, 2011; Yang, 2005). The length of stay in the U.S. was positively related to level of acculturation (e.g., Kim & Chan, 2004; Song et al., 2004; Yang, 2005); most specifically, Jasti, Lee, and Doak (2011) mentioned that participants who had spent at least 8 years the U.S. were more likely to be acculturated than their counterparts. However, in Kim (2007) and Choi, Miller, and Wilbur (2009)'s studies, how long a person stayed in the U.S. was not related to acculturation. Yang (2007) found that length of stay in the U.S. was one of the most important predictors of health status for Korean American women.

In several studies, current age was related to the level of acculturation (e.g., Kim & Chan, 2004; Jang, Kim, & Chiroboga, 2005; Song et al., 2004). Jasti and colleagues' study (2011) showed people under the age of 28 were more acculturated than people over the age of 28. Three other studies reported no relationship between age and acculturation (Choi et al., 2009; Kim, 2007; Park et al., 2003). In Choi and colleagues' study (2009), younger age at immigration, rather than current age, led participants to be more acculturated, and the studies of Jasti et al. (2011) and Lee (2007) had the same result. Several studies found that more highly educated Korean Americans were more

acculturated (e.g., Choi, 2005; Kim & Chan, 2004; Park et al., 2003), but Kim (2009) and Choi et al. (2009) said that there was no relationship between the level of education and acculturation.

Some studies found that Korean Americans with a higher income were more acculturated than those with a lower income (e.g., Choi, 2005; Song et al., 2004; Yang, 2005). In contrast, three other studies revealed that income was not related to acculturation (Choi et al., 2009; Jasti et al., 2011; Kim & Chan, 2004). Jang, Kim, and Chiriboga (2005) and Jasti et al. (2011) said that gender impacted the level of acculturation; specifically, males were revealed to be more acculturated than females, but three other studies described gender as not related to acculturation (Kim, 2007; Kim & Chan, 2004; Yoon, 2005). In Choi et al. (2009) and Jasti et al. (2011)'s studies, single people were more acculturated; in contrast, Jang et al. (2005) said married people were more acculturated. However, Kim (2007) mentioned there was no relationship between marital status and acculturation level. Song et al. (2004) suggested that people who had health insurance were more acculturated than their counterparts. Kim (2007) revealed that the number of people living in a household was not related to acculturation.

Although not absolute due to discordant results and insufficient exemplars, Korean Americans who lived longer in the U.S. (Kim & Chan, 2004; Song et al., 2004; Yang, 2005), were younger (Kim & Chan, 2004; Jang et al., 2005; Song et al., 2004), more highly educated (Choi, 2005; Kim & Chan, 2004; Park et al., 2003), possessed higher income (Choi, 2005; Song et al., 2004; Yang, 2005), were male (Jang et al, 2005; Jasti et al., 2011), immigrated at a younger age to the U.S. (Choi et al., 2009; Jasti et al.,

2011; Lee, 2007), and had health insurance (Song et al., 2004) were more acculturated. The relationship of acculturation to marital status and number of members of a household was not clearly revealed in the previous literature. This indicates a growing selection bias in the population with higher levels of acculturation.

Acculturation and health-promoting behaviors in Korean immigrants.

Twenty-seven studies reported the relationships between acculturation and health-related behaviors, including exercise/relaxation, nutrition/body weight, safety, substance use, and health promotion. There is no consensus on the role of acculturation in relation to health in Korean immigrants, as the results of previous research are mixed and confounding. Although not absolute, the positive evidence was more closely associated with general activity, westernized diet patterns, and oral contraceptives use. The association between acculturation and weight, smoking, drinking, Pap smears, and women's breast exams was mixed. Furthermore, acculturation was not associated with mammograms.

***Exercise/relaxation*.** Acculturated people were more likely to exercise than their counterparts in Choi (2005) and Song and colleagues' (2004) studies. Likewise, less acculturated people participated in fewer vigorous physical activities (Shin, 2011). In contrast, in Yang's study (2007), which had only women participants, the level of acculturation was not related to the amount of physical activity. Acculturation had positive effects through exercise-related self-efficacy, which was positively correlated with leisure-time physical activity (Choi, 2005). People who were involved in physical

activities were also more likely to report better health status than those who were sedentary.

Korean Americans were largely physically inactive (Shin, 2011). However, some studies reported that participation in physical activity, a positive health behavior, has a positive relationship with acculturation (Lee et al., 2000; Song et al., 2004). Low participation in physical activity may be explained by the family-centered and male-centered Korean culture in which family occasions, housework, and child/elderly care take priority over personal activities (Sin, LoGerfo, Belza, & Cunningham, 2004).

Nutrition/body weight. More acculturated people showed more westernized diet patterns. However, diet patterns may be more nutritious among less acculturated Korean Americans. Several studies found that more acculturated people had less healthy diet patterns than their less acculturated counterparts. More acculturated men were more likely to eat out, and eat more fats, fast food, and snacks, and in turn, were more likely to be overweight (Jasti et al., 2011; Lee, 2008; Song et al., 2004). Similar results were reported in three studies (Kim, 2007; Kim & Chan, 2004; Park et al., 2004), but a study by Jackson, Keel, and Lee (2006) that focused on women revealed that eating attitudes were not associated with acculturation.

Koreans who are more acculturated in American society may find a compromise between Korean cultural values and new American values. Studies about the relationship between nutrient intake and levels of acculturation were relatively few compared to descriptions of differences in food intake patterns after immigration (Kim & Chan, 2004). As people became more acculturated, they consumed more American foods and less

traditional food, and this was consistent with other studies (Bertino & Chan, 1986; Grivetti & Paquette, 1978).

Acculturation had a mixed impact on body weight for different genders (Chen, Juon, & Lee, 2011; Lee, 2008; Song et al., 2004), and specifically the relationship between acculturation and weight was stronger among men than women (Chen et al., 2011; Song et al., 2004). However, in Jasti and colleagues' (2011) study, acculturation was not associated with weight, but Korean immigrant men were five times more likely than Korean immigrant women to be overweight. More importantly, eating American fast foods away from home was more closely associated with being overweight in men than women.

A gender-acculturation feature is shown in body weight, and it is generally believed that body weight affects overall health outcomes (Kim & Chan, 2004; Lee et al., 2000; Song et al., 2004). Acculturation seemed to have an association with body mass index in men but not women, and this occurred in other Asian groups (Chen et al., 2011). Other earlier studies reported acculturation as positively related to weight gain in Asian immigrants of both genders (Yeh et al., 2009).

Smoking. Acculturation had mixed associations with smoking status by gender: acculturation was a risk factor for smoking (Unger et al., 2004). The response to acculturation was different between genders: less acculturated men and more acculturated women reported higher rates of smoking (Hofstetter et al., 2003; Juon, Kim, Han, Ryu, & Han, 2003; Song, 2004). However, a few studies showed acculturation and smoking were not associated (Myers, Doran, Trinidad, Klonoff, & Wall, 2009; Weiss, 2002).

Although there is an increased understanding of a variety of smoking-related negative health outcomes, acculturation has a harmful effect on Korean women's (Hofstetter et al., 2004) and adolescents' smoking habits (Unger et al., 2004). Highly consistent gender- or age-acculturation features occurred in the relationship of smoking in other Asian American groups (Choi, Rankin, Stewart, & Oka, 2008). This negative outcome may indicate that acculturation stress and social pressure for immigrants is felt more strongly by women than men compared with what might be expected in Korea.

Substance use. The detrimental effect of acculturation on consumption of alcohol was clearer in women; more acculturated women consumed alcohol more often than men (Song et al., 2004). However, a study on Korean American undergraduate students reported that acculturation predicted decreased drinking; that is, as acculturation increased, students had a lower number of maximum drinks and spent fewer hours drinking (Hendershot, Dillworth, Neighbors, & George, 2008).

Korean American adolescents also struggled with acculturation conflicts. Korean Americans' alcohol consumption was not consistent in this review, but previous studies of alcohol consumption and level of acculturation showed a positive relationship (Black & Markides, 1993; Otero-Sabogal et al., 1995).

Health promotion. Although the aforementioned relationship between acculturation and health was primarily positive, there were mixed results when women's health-promoting behaviors were considered. Few studies focused on women's health behaviors and health attitudes (Jeon et al., 2002; Lee, 2007; Pourat, Kagawa-Singer, Breed, & Sripipatana, 2010; Sohn & Harada, 2005). In the study of Juon, Seo, and Kim

(2002), which had elderly women participants, acculturation was associated with having Pap smears. However, other studies rejected the relationship between acculturation and having Pap smears (Pourat et al., 2010; Sohn & Harada, 2005), between acculturation and mammograms (Jeon et al., 2002; Pourat et al, 2010; Sohn & Harada, 2005), and between acculturation and knowledge of breast self-exams (Sohn & Harada, 2005).

Regarding women's use of healthcare services, the number of studies is insufficient, and three studies used proxy measures including language and length of stay in the U.S. Thus, the relationships between acculturation and health screening behaviors, such as Pap smears and breast exams, were not consistent among the studies (Yi, 1998; Yu et al., 2002).

Also, acculturation was not associated with mammography in all studies with a mammogram variable, unlike Pap smears and breast exams which have mixed relationships. Sohn and Harada (2005) indicated a possible reason: acculturation variables, when used as a major antecedent in the study, may not perfectly describe the concept of acculturation. Another reason was that studies regarding women's health for Korean Americans were collected in Koreatown in Los Angeles, which is the biggest Korean ethnic community in the U.S. Thus, the cultural and language barriers may not be big inhibitors to accessing health services in this population.

In addition, Lee (2007) mentioned that acculturation affected intention to use oral contraceptives; that is, more acculturated women were more likely to use oral contraceptives. That the intent to use oral contraceptives is positively associated with

acculturation is not surprising, as oral contraceptives are a leading method of birth control in the U.S. (U.S. Department of Health & Human Service, 2010).

In some studies, acculturation was considered one of the major predictors of immigrants' health service utilization. A lack of English language fluency had an especially negative effect on healthcare use (Jang, Lee, & Woo, 1998; Shin et al., 2005; Tabora & Flaskerud, 1997). However, in this review, acculturation for Korean immigrants was not a predictor of healthcare use. Also, other studies had a consistent result of an unspecified relationship between acculturation and the use of healthcare services (Jenkins, Le, McPhee, Stewart, & Ha, 1996; Shin, Kim, Juon, Kim, & Kim, 2000).

Acculturation and mental well-being in Korean immigrants.

Mental health cannot be fully explained without understanding its own cultural underpinnings. Immigration itself may be a trigger for mental and emotional difficulties for Korean Americans (Kim et al., 2005). Previous studies have reported a higher incidence of poor mental health among many immigrant populations compared with the dominant population (Aroian & Norris, 2003; Cuellar et al., 2004; Gonzalez, Haan, & Hinton, 2001). The stressful circumstances of immigrants' acculturation may strongly affect individuals' mental resilience (Berry, 2006; Noh & Kaspar, 2003; Oh et al., 2002), as seen in the relationship between acculturation and depressive symptoms described in studies on other ethnicities throughout immigration history (Mehta, 1998; Mui & Kang, 2006; Nicassio, Solomon, Guest, & McCullough, 1986). The existing literature on the

relationship between acculturation and mental distress showed strongly negative linkage (Chiriboga, Black, Aranda, & Markides, 2002; Gonzalez et al., 2001).

Although the history of Korean U.S. immigration is relatively short, studies on mental health are plentiful; however, gaps still exist. There is no consensus on the role of acculturation in relation to mental health outcomes in immigrants as previous research has yielded mixed results. Existing studies of immigrants have predominantly focused on negative mental health outcomes such as depression, stress, or anxiety. Despite the high prevalence of depression, a lack of systematic research on the mental health of Korean immigrants has resulted in a poor theoretical framework for culturally relevant care for Korean immigrants. Although it is commonly accepted that transitioning to a new culture can cause stress that impacts psychological well-being, the relationship between acculturation and mental health is complicated.

Twenty-five studies reported outcomes based on level of acculturation and mental health including depression, stress, and quality of life. This includes studies that focused solely on mental health as well as others that focused on mental health and additional variables. Overall, findings about associations between acculturation and mental health were mixed. Several studies about Korean immigrants reported evidence of a positive association between acculturation and depression (Choi et al., 2009; Jang & Chiriboga, 2009, 2011; Kim 2009), but some studies reported no relationship between acculturation and depression (Lee et al., 2004; Shin et al., 2007; Sin et al., 2010). In studies of Ayers et al. (2009), Oh, Koeske, and Sales (2002), and Shim and Schwartz (2008), higher acculturation was a predictor of low acculturative stress, and hence, lower depression,

which in turn contributed to better quality of life for Korean Americans (Jang et al., 2005; Lim, Yi, & Zebrack, 2008). Also, acculturation was negatively related to anxiety and stress (Ayers et al., 2009; Jang & Chiriboga, 2009). The existing literature on the relationship between acculturation and mental distress showed strongly negative linkage (Chiriboga et al., 2002; Gonzalez et al., 2001). In a study about young adolescents by Choi, Stafford, Meininger, Robert, and Smith (2002), Korean Americans reported higher mental distress than Caucasians, and in another study about people over the age of 40 by Browne, Fong, and Mokuau (1994), Korean Americans demonstrated higher depressive symptoms than other Asians.

Acculturation was a predictor of quality of life (Seo, 2009) and life satisfaction (Yoon, 2005). Acculturation has been explored with various psychological factors, but one study focusing on self-esteem in Korean Americans showed no relationship between acculturation and self-esteem (Lee, 2002). The findings in the existing literatures are inconsistent; some showed a positive relationship (Meyler, Stimpson, & Peek, 2006; Valentine, 2001), while others showed no relationship (Joiner & Kashubeck, 1996).

The studies about immigrants' negative feelings such as depression and stress were numerous, but studies about positive effects (i.e., happiness) were not as well-documented. However, immigration-related stress's negative effect on depression was well known, and a similar effect was found in positive feelings as well (Shin et al., 2007).

Although this literature review did not find enough evidence to define the relationship of Korean Americans' well-being to acculturation, acculturation acts as one of the predictors of immigrants' mental well-being, and this was consistent with other

studies on other ethnic groups (van Servellen, Chang, & Lombardi, 2002; Yang & Wang, 2011).

Summary of Part 3: Acculturation

Acculturation is a complex and bidirectional concept. Acculturation contributes to changes in social, psychological, and cultural aspects of immigrants' lives and to their attitudes, beliefs, and behaviors. Acculturation of Korean immigrants must be examined in multiple research studies to better understand acculturation-related health outcomes and how Korean immigrants respond to their new culture.

Through the review of literature, the effect of acculturation on Korean immigrants' health behaviors and mental well-being was reviewed. The effects of acculturation on health-related behaviors and mental well-being are complicated and confounding in Korean immigrants. Although this literature review did not find enough evidence to definitively state the relationship between Korean Americans' well-being and acculturation, acculturation is one of the predictors of immigrants' mental well-being, which is consistent with studies on other ethnic groups.

Part 4. Transition Conditions of Korean Immigrants

According to immigration transition theory (Meleis et al., 2000), transition conditions, which may facilitate or inhibit health transitions, play important roles in buffering between transition properties and the indicators of healthy transition. The ability of the self to adjust to a new situation is a powerful mediator for allowing an individual to adapt. Family relationships and socially help-seeking behaviors play a significant role in an immigrant's well-being and how he/she copes with stress and lifestyle adjustments. Thus, this section describes self-control, family functioning, and social resourcefulness as functioning mediators between culture and lifestyle.

Self-Control

Individuals' self-control is beneficial when people have to adapt to new conditions or needs in a new country (Tangney et al., 2004). When individuals relocate to a new country, the readjustment of the self is one of the buffers to achieve individual well-being. Self-concept is substantially influenced by culture and social experiences because the relationship between self and society is inseparable (Bada, 2003). Thus, the self continuously modifies and develops to adjust to society. The self is adaptive and dynamic rather than static. The change of self-concept in a different culture may modify immigrants' behaviors because of intercultural experiences.

The value of 'self' shows a substantial difference between Western and Eastern cultures; thus, immigrants may experience multidimensional changes in the structure of the self (Geertz,, 1973; Hollan, 1992; Mageo, 1998). The self-concept has origins in traditional Korean cultural values, like Confucianism and collectivism.

In Korean culture, the group is more valued than the individual self and the individual identifies with the group. This concept originated from 'we'ness based on collectivism; thus, individuals from this cultural background emphasize we-self rather than my-self (Roland, 1988). Also, Confucianism contributed to the shape of the unique concept of self. In hierarchical Confucian societies, there are various social roles prioritized above self. A study of 493 college students (Rhee et al., 1996) reported that Koreans were more collectivistic and less individualistic than European Americans. Understanding Korean's unique self-concept allows a person to understand the components of their well-being. In order to better fit into a new culture, one must have self-control, which allows one to adapt his/her lifestyle to a new culture (Tangney et al., 2004).

Self-control identifies how social interactions influence the individual's capacity for self-control. The concept of self-control is defined as "the ability to override or change one's inner responses, as well as to interrupt undesired behavioral tendencies and refrain from acting on them" (Tangney et al., 2004). Self-control is the effort of control over the self by the self, that is, an attempt to control or change how one thinks, feels, or behaves (Muraven & Baumeister, 2000). Better self-control generates a broad range of positive outcomes in life, while a lack of self- control induces negative outcomes, affecting academic achievement, psychological adjustment, health-related behaviors, and interpersonal relationships (Gerrard, Gibbons, Houlihan, Stock, & Pomery, 2008; Tangney et al., 2004; Vazsonyi, Trejos-Castillo, & Huang, 2006; Wills, Sandy, & Yaeger, 2002).

The self is influenced by culture and has an impact on health outcomes. The self-mediating between culture and health components is important to a person who faces a new culture and health challenges. This study examined the mediating effects between culture and health outcomes that come from relocating Koreans to a new country.

Family Functioning

Families are at the core of determining healthy lifestyles and well-being, and the ability of family members to communicate, relate, maintain relationships, make decisions, and solve problems is essential for immigrants, who are sometimes isolated from family and experience changes in a group of intimates with strong emotional bonds (identification, attachment, loyalty, reciprocity, and solidarity). Family is defined as "a group of intimates with strong emotional bonds (identification, attachment, loyalty, reciprocity, and solidarity) and with a history and a future as a group" (Gilliss, Highley, Roberts, & Martinson, 1989; Sincrope, 2007, p. 7). Family functioning is defined as the ability to "provide for the biological, psychological, and social development and maintenance of family members" (Steinhauer et al., 1984, p. 78). An individual family's values are a leading influence on the health of all other family members and are essential in determining healthy lifestyles and mental well-being. Families have a powerful influence on health-promoting behavior (Campbell, 2003).

Family relationships are dominant among the major factors associated with the cultural identity of Korean Americans. Korean culture and values emphasize that personal values and desires are often sacrificed for the well-being of the family. Exploring the cultural context within Korean immigrant populations is required to

understand family environments. Also, better understanding of immigration transitioning must include the influence of family relationships because immigration to the U.S. is typically a family issue (Rumbaut, 1997). The family environment is influenced by culture and impacts immigrants' well-being. The family is viewed as the primary influence on healthy growth and development. According to Friedman (1998), family health maintenance and promotion is a major task across the individual's life span for both the individual family members as well as the family as a unit.

Better family functioning in immigrant groups plays a critical protective role against acculturative stress (Arends-Toth & Van de Vijver, 2006; Castillo, Conoley, & Brossart, 2004; Leibkind, Jasinskaja-Lahti, & Solheim, 2004). Unresolved immigration stress has the potential to disrupt the adaptation level of the family. Family functioning is one way to maintain the integrity of the cultural system when cultural changes influence family life events. It can either draw families together or generate familial conflicts. Families with stable relationships and adequate support for each other may be able to adjust to the dominant society and maintain their quality of life. However, families with high levels of stress may only provide minimal support for each other or ignore others' needs, especially the more vulnerable family members (Sloper, 2000).

Family is regarded as a primary symbol of culture and ethnicity, thus family and family socialization for immigrants are important to improve their quality of life (Sodowsky & Lai, 1997). Family values for Koreans are based on traditional cultural values, especially Confucianism and collectivism (Oak & Martin, 2000). They emphasize

close family ties, respect for parental authority and for elders, duty to provide elder care, and self-sacrifice to preserve family honor (Min, 1998).

Korean American families have more distinct ties to Korean culture than the American culture although most immigrants live in both original and host cultures (Choi & Kim, 2010). Acculturation is a complex task for Korean families (Choi & Kim, 2010). The original language and some cultural behaviors tend to be forgotten gradually as generations live longer in the host culture (Kibria, 2002; Louie, 2004), but Korean families try hard to maintain the original cultural and ethnic identity (Choi & Kim, 2010).

Family context has been found to be the primary source of health-related behavior, health beliefs and attitudes, and social support (Doherty & Campbell, 1988; Knafl & Gillis, 2002; Weihs, Fisher, & Baird, 2002). Family functioning can affect an individual's beliefs and values regarding health and illness. Research indicates that family relationships are one of the dominant predictors of illness and social connection (Berkman, 2000; Orth-Gomer, Rosengren, & Wilhelmsen, 1993; Rankin, Galbraith, & Huang, 1997); better family functioning has positive health outcomes. The traditional cultural values are challengeable and negotiable for immigrants in the process of acculturation (Foner, 1997). Thus, the challenges faced by immigrant families due to cultural transition may impact healthy immigration.

Social Resourcefulness

Individuals and families migrate for various reasons, and they may need different resources and different support to avoid or decrease potential difficulties. Individuals with better social support are reported as more attractive, interesting, and socially

competent than those with lower support (Sarason, Sarason, Hacker, & Basgam, 1985). Social resourcefulness may be essential to those who are experiencing higher levels of stress, such as immigrants and their families. Individuals with plentiful resourcefulness have been found to be more adaptive and have better social role functioning that allows them to deal with life challenges more effectively and achieve more positive health outcomes, life satisfaction, and quality of life (Bekhet, Zauszniewski, & Wykle, 2008; Zauszniewski, 1994; Zausziewski & Chung, 2001).

Individuals use social resourcefulness in covert and overt behaviors to establish and maintain supportive relationships with others and to receive help from others (Rapp et al., 1998). Hinson and Swanson (1993) define help-seeking behaviors as seeking help from others, including family members, friends, and ministers or health counselors. Thus, social resourcefulness is important for engaging in help-seeking behavior and seeking social support from others (Rapp et al., 1998). Seeking help from others greatly impacts individuals' well-being by enabling them to overcome life challenges and to promote health (Quayhagan & Quayhagan, 1988; Rapp et al., 1998). Social resourcefulness for help-seeking embraces usage of formal help and informal help from family members, friends, and others. That is, better social resourcefulness may be a facilitator to individuals' well-being as they experience transitional circumstances. These help-seeking behaviors must be embraced to achieve optimal health and function.

Despite vulnerable individuals or families' need for social resourcefulness, Vogel, Larson, and Wester (2007) reported potential barriers to seeking help such as social stigma, fear of emotion, anticipated utility and risks, and self-disclosure. Also, the

important factors to facilitate or avoid help-seeking are considered cultural factors (Atkinson, Whitely, & Gim, 1990; Kushner & Sher, 1989; Tata & Leong, 1994).

Many studies have reported the relationships between help seeking and health outcomes in various participants, especially those who are most vulnerable, including the elderly and those with chronic conditions (Blaum, Liang, & Liu, 1994; Carey, Carey, Carnrike, & Miesler, 1990; Kennett & Ackerman, 1995; Rapp et al., 1998; Quayhagan & Quayhagan, 1988). A significant positive relationship between social resourcefulness and psychological health in older adults was found in previous studies (Quayhagan & Quayhagan, 1988; Rapp et al., 1998). Other studies have reported a significant negative association between social resourcefulness and physical functioning in younger and older adults (Blaum et al., 1994; Jorm et al., 1993). However, although immigrants need to help others, the influence of social resourcefulness on immigrants' well-being has not been examined. Also, little research has examined whether there are cultural impacts on how people utilize their social resourcefulness.

Different cultures have different social relationships. Physical social cues are different in Asian and American cultures. Eye contact is seen as a positive and trustworthy trait in American culture, while in Asian cultures direct eye contact is often seen as rude or disrespectful. Another example is the role of posture in the two cultures; while in Asian cultures a rigid posture is seen as powerful and credible, in American cultures people with more relaxed posture are sometimes seen as more successful (Badler & Allbeck, 2004). Previous studies have reported the various cultural differences in

social relationships; however, there is a lack of studies that report the relationships between social relationships and health components based on cultural contexts.

Social support is used to examine buffering effects between various stressors and diverse physical and psychological health outcomes (Ameren, 2009; Bowling et al, 2004; Viswesvaran, Sanchez, & Fisher, 1999). However, the results are inconclusive, mixed, and inconsistent (Beehr & Glazer, 2001). Beehr and Glazer (2001) have reported that mixed results are due to cultural impacts on studies.

Despite the fact that only a few articles have addressed cultural components to understand the buffering effects of social support (Ameren, 2009; Beehr & Glazer, 2001; Bhagat, Kedia, Harvestion, & Triandis, 2002; Taylor et al., 2004), evidence of the impact of cultural contexts on social support is existing (Glazer, 2006). Social support across cultures may differ depending on the cultural values of individualism or collectivism (Ameren, 2009; Beehr & Glazer, 2001). Members of individualistic cultures seek social support from superiors to help their advancement toward individual goals, while members of collectivistic cultures seek social support from colleagues since collectivistic cultures focus more on common goals and group harmony (Glazer, 2006).

Summary of Part 4: Transition Conditions of Korean Immigrants

Personal, family, and social functioning served as buffering factors between acculturation and health outcomes, healthy lifestyles, and well-being. Self-control, family functioning, and social resourcefulness were reviewed based on the cultural backgrounds of Korean immigrants. Self-control, which is control over the self by the self, is an essential factor in adapting to a new country. Families are at the core of determining

healthy lifestyles and well-being. Family functioning helps to maintain the traditional cultural values when cultural changes influence family life. Social resourcefulness is seeking help from both formal and informal sources. These three transition conditions for immigrants, self-control, family functioning, and social resourcefulness, are influenced by the immigrant's own culture and values, and they may have an impact on adjusting to healthy lifestyles in a new country and on well-being.

Summary

According to the 2010 U.S. Census, about 40 million foreign-born individulas live in the U.S. and the number of Korean Americans has increased by about 32% from 2000 to 2010. Although there are many immigrant groups, Korean immigrants are one of the fastest growing groups, but they have relatively poor health-promoting behaviors and a low acculturation level.

Immigration is uniquely experienced based on their own cultural background which affects a transition in an individual's lifestyle, changing his or her beliefs and values related to health and illness. Although Korean immigrants' transitioning has been steadily studied in cultural contexts, several issues are still remaining.

A lack of cultural understanding about Korean immigrants could result in less than appropriate care. Thus, studies about multiple concepts of transition are needed because migration transition has a multiple and complex domain structure. Immigrants' self-control, family functioning, and social resourcefulness, which are influenced by Koreans' own culture and values, were examined as mediating factors on the impact of transitioning to the U.S. on Korean immigrants' health behaviors and mental well-being.

CHAPTER 3: METHODOLOGY

This study examined four specific aims to explore the impact of immigration transition on the health-promoting behaviors and mental well-being of Korean immigrants in the U.S. First, the researcher proposed to examine the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S. and S. Korea. Second, this study aimed to compare differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Koreans in the U.S. and in S. Korea. Third, this study identified the significant predictors of health-promoting behaviors and mental well-being for Koreans in the U.S. and in S. Korea. Finally, the researcher proposed to determine mediating effects of self-control, family functioning, and social resourcefulness on the relationship between acculturation and health-promoting behaviors and mental well-being among Koreans in the U.S.

This chapter describes the research methodology that was applied in this study. First, the research design for addressing the research purposes and questions is described. Second, the appropriate population and the rationale for determining sample size are explained. Then, the procedures for data collection, instruments, and data analysis are provided. Lastly, the translation strategy of instruments, the procedures and findings of a pilot study for determining the reliability of translated instruments, and an evaluation of the overall research plan are reported.

Research Design

A cross-sectional, comparative correlational design was used to examine the effect of transitioning to the U.S. on health behaviors and mental well-being of Korean immigrants compared to Koreans in S. Korea. A cross-sectional study was used "to investigate associations between risk factors and the outcome of interest … at a given time point" (Leven, 2006, p. 24). This study design is appropriate for describing the state of phenomena or for describing associations among contemporary variables (Polit & Beck, 2008). Descriptive correlational studies were used to describe the associations among variables (Polit & Beck, 2004). Thus, a cross-sectional, descriptive correlational comparative design was appropriate for this study to explore differences in well-being after transitioning to the U.S. compared to those of Koreans in S. Korea.

Study Sample

The target population of this study was community-residing Koreans in the U.S. and S. Korea. A non-probability, convenience sampling strategy was used to recruit participants in the U.S. and S. Korea. Koreans residing in the U.S. who met the inclusion criteria were invited to participate. Inclusion criteria for Koreans in the U.S. were as follows:

(a) at least 18 years of age,

(b) self-identify as a first-generation Korean immigrant,

(c) read and write Korean or English,

(d) reside in the U.S., and

(e) are willing to participate.

Inclusion criteria for Koreans residing in S. Korea used matched age and gender controls with Korean immigrant participants as well as inclusion criteria discussed for the U.S. immigrant group. Thus, inclusion criteria for Koreans in S. Korea are as follows:

(a) at least 18 years of age,

(b) age matched to U.S. immigrant sample,

(c) gender matched to U.S. immigrant sample,

(d) read and write Korean, and

(e) are willing to participate.

The one exclusion criterion for Koreans in S. Korea was that no participants could have spent more than six months in the U.S. In addition, a snowball sampling strategy was also used by asking participants to introduce neighbors, friends, or relatives to the study through the individual's personal network (Biernacki & Waldorf, 1981).

Sample Size Determination

To calculate adequate effect size, this study used literature reviews and the result of a pilot study. First, the effect size was determined based on a literature review about the relationship between acculturation and health outcomes. Although there was no study on the relationships between acculturation with a perspective of transition theory and well-being, the most similar existing studies were used. For multiple and partial correlation based on Cohen (1992), small, medium, and large effect sizes (f^2) are .02, .15, and .35, respectively, and population effect size index is $f^2 = R^2/1\text{-}R^2$. Through the existing literature review, the effect sizes on the population ranged from medium to large

(f^2 = .12 - .49) and the average effect size was .20 (Hovey, 2000; Miller & Chandler, 2002; Mui & Kang, 2006; Schnittker, 2002; Torres & Rollock, 2007) (Table 3.1).

Table 3.1. Literature Review for Population Effect Size

Reference	**Variables**	**Effect Size (f^2)**
Torres & Rollock (2007)	Acculturation, Intercultural competence, depression	.28
Miller & Chandler (2002)	Age, English usage, demands of immigration, resilience, depression	.49
Hovey (2000)	Acculturative stress, religion, social support, suicidal ideation	.22
Mui & Kang (2006)	English proficiency, religiosity, depression	.12
Schnittker (2002)	Acculturation, self-esteem, social support, discrimination	.11

In addition, the appropriate effect size for the study was determined from the results of a pilot study. The selected socio-demographic/immigration characteristics (age, family income, health status, and English proficiency), behavioral and cultural value acculturation, self-control, family functioning, social resourcefulness, and health-promoting behaviors were used for identifying significant predictors of mental well-being. The pilot study showed that the R^2 between selected socio-demographic/immigration characteristics and mental well-being was .304; after the addition of behavioral and cultural value acculturation, the R^2 increased to .516; and then, after adding self-control,

family functioning, and social resourcefulness, the R^2 was .645. Lastly, health-promoting behaviors added another 4.8% of explanation to mental well-being. From the finding of the pilot study, the effect size f^2 was greater than medium. Thus, a medium effect size was enough for this study based on the literature review and the pilot study, which is consistent with the suggestion of Cohen, that is, a significance level of .05 and an 80% level of power are widely used in behavioral research studies (Cohen, 1992).

Based on Power Analysis (G Power 3.1.7) (Erdfelder, Faul, & Buchner, 1996) estimates, to have 10 independent variables in multiple regression analysis (fixed model, R^2 increase), a sample size of 68 was required to have a sufficient power of .80 with the medium effect size of .15. Also, from a T-test to compare two independent means, a sample size was estimated at 128 (each 64) using a medium effect size and power of .80.

The average correlation coefficient, calculated from the pilot study, was limited because the sample in the pilot study was small (N = 30). To be conservative, a 10% drop rate was assumed due to incomplete data or nonresponsiveness. Thus, the initial targeted number of participants needed for the combined sample was a minimum of 154; 77 participants were required in the U.S. with the same number required for S. Korea.

After collecting data, a total of 192 Koreans (105 in the U.S. and 87 in S. Korea) participated in this study; 30 participants for a pilot study were included among the Korean immigrants. The powers of this study with a medium effect size of .15 and an *alpha* of .05, were .85 (S. Korea) and .95 (U.S.) from the G. Power.

Study Procedures

Sampling Procedures

The study took place in two countries: the U.S. and S. Korea. The recruitment was similar in both countries. These are discussed separately for each country.

U.S. Korean participants were recruited using convenience and snowball sampling in community-based settings. For identifying Korean immigrants in the U.S., the primary geographic region for data collection was Austin, TX, and neighboring cities. According to the 2010 U.S. Census, the number of Korean Americans in Austin was about 8,000. In order to target this group, Korean ethnic churches served as the major setting to gather data from the Korean immigrant population. Approximately 70% of Korean immigrants have enrolled in Korean churches in the U.S., so Korean churches were an effective setting to meet Korean immigrant participants (Hurh & Kim, 1990). Also, Korean ethnic small businesses, such as grocery stores, restaurants, and hair salons, were targeted for recruiting Korean immigrants. The investigator posted flyers in these businesses as well as in the Korean churches. The flyers asked potential participants to contact the investigator by email or phone. No flier was posted without permission of the owner of the business or the pastor of the church.

In order to identify Koreans in S. Korea, convenience and snowball sampling were also used. A research assistant, trained in the ethical conduct of research, recruited participants in the city of Seoul and neighboring cities in S. Korea. The research assisitant also recruited S. Korean participants from his personal network.

Data Collection Procedures

Approval from the School of Nursing Departmental Review Committee and the Institutional Review Board (IRB) of the University of Texas at Austin was obtained prior to conducting this study (APPENDIX B). Data collection occurred sequentially in the U.S. and then in S. Korea to match age and gender of S. Koreans with Koreans in the U.S. Data collection in the U.S. began on July 13, 2013, after the study was approved by the IRB, and finished on September 5, 2013. Data collection in S. Korea began on August 3, 2013, after approving the IRB amendment for adding a trained Korean research assistant to collect data in S. Korea, until September 8, 2013. The investigator or research assistant did not make any contact with participants prior to approval from the IRB.

U.S. Korean Immigrant Participants: The investigator contacted participants individually or in groups. The investigator explained the purpose and potential advantages and disadvantages of the study to the potential participants. If Koreans in the U.S. showed interest to take part in this survey, the investigator asked the following two questions to determine their eligibility for the study: "Are you 18 years of age or older?" and "Are you a first generation Korean immigrant?"

If they were eligible based on their responses, the investigator provided and reviewed the consent form in their preferred language. The consent forms in English and Korean are attached (APPENDIX C). The investigator spent time with the potential participants allowing them to ask questions about the ongoing study. After asking if they had any questions, they were asked to participate. If they consented and signed the

consent form, the participants were provided an English or Korean questionnaire package in the language of their preference with two options for completing the questionnaires.

If the participants wanted to complete the survey at that time, the investigator spent time with the participants and waited for them to complete the questionnaire. If he/she wanted to complete it at home or in a private place, the investigator provided the questionnaire with a pre-addressed and stamped envelope and ask him/her to mail it back to the investigator.

S. Korean Participants: Korean participants in S. Korea were recruited using a trained Korean research assistant who speaks Korean. The investigator employed the Korean research assistant residing in S. Korea and trained him regarding the purposes, procedures, and possible benefits and risks of this study as well as privacy and confidentiality of participants. In order to use a matched age and gender controlled group, recruiting Koreans in S. Korea occurred after starting to recruit Koreans in the U.S. This allowed the research assistant to have information regarding the age and gender of Koreans in the U.S. to match with Koreans in S. Korea.

The research assistant contacted potential participants individually or in groups. The research assistant explained the purpose and potential advantages and disadvantages of the study to the participants. The research assistant spent time with the potential participants allowing them to ask questions about the ongoing study.

If Koreans in S. Korea showed interest to take part in this survey, the research assistant asked them the following two questions: “Are you 18 years of age or older?” and “Have you spent more than 6 months in the U.S.?” If a potential participant was

willing to take part in the survey and met the inclusion criteria, he/she had two options, which was the same recruiting method for Koreans in the U.S.

Instrumentation

The instruments for this study consisted of self-report questionnaires. The survey took approximately 25 minutes, which was estimated from the pilot study. Based on the theoretical underpinning adapted from transition theory (Meleis et al., 2000), this study explored the nature of transition operationalized as acculturation; transition conditions operationalized as self-control, family functioning, and social resourcefulness; and indicators of transition operationalized as health-promoting behaviors and mental well-being.

Instruments for Korean immigrants in the U.S. included a socio-demographic profile, immigration information profile, the Korean American Acculturation Scale (Lee, 2004), the Brief Self-Control Scale (Tangney et al., 2004), the Family Assessment Device-General Functioning (Epstein et al., 1993), the Social Resourcefulness Scale (Rapp et al., 1998), the Personal Lifestyle Questionnaire (Muhlenkamp & Brown, 1983), and the Warwick-Edinburgh Mental Well-Being Scale (Tennant et al., 2006). All the questionnaires for Korean immigrants in the U.S. were in English or Korean (Table 3.2) (Appendix D). The participants had the choice of completing the questionnaires in English or Korean, depending on the participants' preferences.

Instruments for Koreans in S. Korea included a socio-demographic profile, the Brief Self-Control Scale, the Family Assessment Device-General Functioning, the Social

Resourcefulness Scale, the Personal Lifestyle Questionnaire, and the Warwick-Edinburgh Mental Well-Being Scale. All the questionnaires for Koreans in S. Korea were in Korean.

Table 3.2. Concepts Studied and Corresponding Questionnaires

Concept	Questionnaire	Item #	Reliability
Socio-demographics	Socio-demographic Information Form	9	
Immigration Information	Immigration Information Form	4	
Acculturation	The Korean American Acculturation Scale	33	.70-.92
Self-Control	The Brief Self-Control Scale	13	.79-.88
Family Functioning	The Family Assessment Devise-General Functioning	12	.82-.92
Social Resourcefulness	The Social Resourcefulness Scale	20	.85-.89
Health-Promoting Behaviors	The Personal Lifestyle Questionnaire	24	.72-.80
Mental Well-Being	The Warwick-Edinburgh Mental Well-Being Scale	14	.87-.91

Socio-demographic Information Questions

Socio-demographic information questions were developed by the investigator. Socio-demographic background information included age, gender, living arrangements, perceived current health status, marital status, educational level, employment status, health insurance, and perceived family income sufficiency. Among these variables, age,

family income, and health status were employed as demographic factors to examine predictors that influence immigration transition's impact on health. The rest of the variables were used to describe and compare the demographic characteristics of the populations.

Immigration Information Questions

Immigration information questions were also developed by the investigator. Individual immigration characteristics to be measured included duration of residency in the U.S., age on arrival to the U.S., and English use and proficiency. They served to describe the demographic characteristics of Koreans in the U.S. English proficiency was used as a predictor of health behaviors and well-being among Koreans in the U.S.

The Korean American Acculturation Scale (KAAS) (Lee, 2004)

The level of acculturation was measured by the Korean American Acculturation Scale, which measures Korean Americans' acculturation characteristics and patterns. The KAAS is a 33-item scale consisting of two subscales, the behavior KAAS and the cultural value KAAS. Behavioral acculturation is measured by a 15-item subscale that consists of two dimensions: usage and social contact. The 18-item subscale of cultural value acculturation includes three dimensions: collectivism, success, and self-control (Lee, 2004). This 33-item scale consists of a 5-point Likert scale, ranging from one (strongly disagree) to five (strongly agree). Lower scores indicate a greater degree of acculturation.

Representative example items for the behavioral acculturation dimension subscale are "I read books in Korean" and "My family cooks Korean foods." For the cultural value

acculturation dimension, representative items are “One should follow the role expectations of one’s family (parents, siblings),” “Failure in work brings shame to the family,” and “The ability to control one’s emotions is a sign of strength.”

In a pilot study by Lee (2003), acceptable-to-good reliability alphas showed: .85 for usage, .92 for social contact in the behavioral acculturation dimension, .78 for collectivism, .77 for success, and .70 for self-control in the culture value acculturation dimension. In a follow-up study, which consisted of 663 Korean Americans, Cronbach’s alpha reliability was also acceptable: .91 for usage, .82 for social contact in the behavior acculturation dimension, .73 for collectivism, .77 for success, and .70 for self-control in the culture value acculturation dimension (Lee, 2004). In a study of Park (2010), good Cronbach’s alphas were also revealed: .89 for behavioral acculturation and .82 for cultural value acculturation in a study of 376 first generation Korean fathers living in the U.S.

In a study of 273 Korean Americans and Koreans, a factor analysis of the behavioral acculturation scale yielded factor loadings of .61 or above, and cultural value acculturation yielded factor loadings of .48 or above (Lee, 2004). The factor solution explained 61.4% in behavioral acculturation and 47.6% in cultural value acculturation of the total variance. The KAAS was significantly moderate when correlated with ethnic orientation scale: .17 in behavioral acculturation and .42 in cultural value acculturation (Park, 2010).

The Brief Self-Control Scale (BSCS) (Tangney et al., 2004)

Self-control, defined as a self-capacity to adapt to new situations, thereby creating a best fit between self and the outer world (Rothbaum et al., 1982; Tangney et al., 2004), was measured by the Brief Self-Control Scale. The Brief Self-Control Scale was developed to assess an individual's self-control based on a general self-control scale (Tangney et al., 2004). It measures dispositional self-regulatory behaviors. The BSCS is a 13-item, 5-point Likert questionnaire, ranging from one (not at all like me) to five (very much like me). The possible range of scores is 13 to 65. Higher total scores indicate greater self-control. Representative example items are "I am lazy" and "I say inappropriate things."

Alphas of internal consistency reliability ranged from .83 to .85, and test-retest reliability was .87 for a sample of 233 participants, which indicates good reliability of the BSCS (Tangney et al., 2004). Also, the good reliability of this scale was .85 in a study of 584 incarcerated offenders (Mathews, Youman, Stuewig, & Tangney, 2007). For a study of 351 individuals, Cronbach's alpha of the BSCS was .81 (De Ridder, De Boer, Lugtig, Bakker, & Van Hooft, 2011), and for a sample of 274 individuals, the internal reliability of alpha was .88 (Duckworth, Peterson, Mattews, & Kelly, 2007). The internal consistency in 531 undergraduates was scored as acceptable, .79 (Trumpeter, Watson, & O'Leary, 2006).

The BSCS was correlated with better adjustment, less binge eating and alcohol abuse, better relationships and interpersonal skills, secure attachment, and more optimal emotional response (Tangney et al., 2004). In a study conducted by Trumpeter, Watson,

and O'Leary (2006) with 531 students, the BSCS was significantly small or moderately correlated with self-esteem (r = .19), leadership/authority (r = .09), superiority/arrogance (r = .11), and self-absorption/self-admiration (r = .11).

The Family Assessment Device-General Functioning (FAD-GF) (Epstein et al., 1983)

Family functioning, defined as the ability to support and develop as a family member (Steinhauer et al., 1984), was measured by the general functioning scale of the Family Assessment Device (FAD). The FAD was originally developed as a 60-item self-report questionnaire to assess the level of family functioning outlined in the McMaster Model of Family Functioning (Ryan, Epstein, Keitner, Miller, & Bishop, 2005). The FAD has seven dimensions including problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functioning. The general functioning scale of the FAD was developed to assess the overall health profile of family and correlated with the overall FAD (Epstein et al., 1983). Kabacoff, Miller, Biship, Epstein, and Keitner (1990) and Byles, Byrne, Boyle, and Offord (1988) suggested that the FAD-GF was strongly supported as a single index representing overall family functioning. The FAD-GF is a 12-item 4-point Likert questionnaire, ranging from one (strongly agree) to four (strongly disagree). Lower scores indicate higher healthy family adjustment. Example items are "We confide in each other" and "Planning family activities is difficult because we misunderstand each other."

Cronbach's alpha of the general functioning of the FAD was good: .92 in the original study (Epstein et al., 1983) and .86 in the later study (Musil, Warner, Zauszniewski, Jeanblan, & Kercher, 2006). This was consistent with a study of 74

participants in which the Cronbach's alpha was .82 (Saied, 2006). Also, coefficient alphas ranged from .83 to .86 in various samples (Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990), which are consistent with the original study. Test-retest reliability was acceptable, .71 (Epstein et al., 1983).

The FAD had low correlations with social desirability, ranging from -.06 to -1.5 (Miller et al., 1985). It was moderately correlated with other self-report measures of family functioning (Miller et al., 1985). The general functioning scale strongly correlated with the other FAD subscales, ranging from .85 to .88 in the nonclinical, psychiatric, and medical samples (Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990). The concurrent validity was estimated from the FAD-GF, and showed significant correlation with family adaptability/cohesion and family unit in a study of 45 samples (Miller, Epstein, Bishop, & Keitner, 1985). Discriminative validity of the overall FAD was assessed in clinician-rated healthy and unhealthy families; it differentiated significantly, which indicated unhealthy families rated by the clinicians had poorer family functioning (Miller et al., 1985).

The Social Resourcefulness Scale (SRS) (Rapp et al., 1998)

Social resourcefulness was measured by the Social Resourcefulness Scale (Rapp et al., 1998). Social resourcefulness is conceptually defined as the individual's behaviors to establish and sustain help-seeking relationships (Rapp et al., 1998). The SRS was chosen to measure this concept because it assesses an individual's frequency of help-seeking behaviors in situations where help was needed, and consists of three domains: self-regulating, helper-regulating, and relationship-regulating behaviors. This 20-item

scale consists of a 5-point Likert scale that ranges from zero (never do it) to four (always do it) with higher scores indicating a greater level of social resourcefulness. Total scores range from 0 to 80. Questions begin with "When you need help, how often do you…" and follow with questions like "tell someone how their help makes you feel?" or "look for professionals who could help you?"

A pilot study of 38 individuals revealed that the SRS instrument had very good internal reliability (Cronbach's alpha = .85) and acceptable test-retest reliability (r = .79) (Rapp, Shumaker, Schmidt, & Naughton, 1995; Rapp et al., 1998). This was consistent with another study of 65 participants with a good Cronbach's alpha of .85, with a mean of 42.5 (SD = 12.1, ranged 13 to 65) (Rapp et al., 1998). Also, a study with 190 individuals showed a good alpha of internal consistency (r = .89) (Martinez, 2002).

Construct validity by Rapp et al. (1998) was determined by comparing the SRS to other measures of social support and well-being in the 65 caregivers. The SRS was significantly correlated to social support (r = .43), social network size (r = .31), quality of life (r = .37), and health status (r = .26).

The Personal Lifestyle Questionnaire (PLQ) (Muhlenkamp & Brown, 1983)

The Personal Lifestyle Questionnaire was applied to examine health-promoting behaviors, defined as behaviors to produce an optimal well-being and realize health potential (Pender et al., 2006). This instrument was chosen because it measures the extent to which individuals participate in health-related or health-promoting activities for healthy lifestyles (Mahon, Yarcheski, & Yarcheski, 2002). It was grounded on the behaviors most commonly performed to promote health suggested by Harris and Guten

(1979). The 24-item instrument consists of six subscales: exercise, nutrition, relaxation, safety, substance use, and health promotion. Each item is scored from one to four, ranging from never to almost always, using a Likert scale. The total score represents the sum of the subscales and ranges from 24 to 96, with higher scores indicating a greater number of positive health behaviors. The example items are "see a health-care provider for a check-up at least yearly" and "eat at regular times during the day."

A study of 222 adolescents showed the acceptable coefficient alpha for the total PLQ, .73 (Mahon et al., 2002). Test-retest reliability coefficients of .78 and .88, and Cronbach's alphas of .74 and .76 were reported for the total lifestyle score (Muhlenkamp & Brown, 1983). Also, acceptable coefficient alphas for the total PLQ were reported, ranging from .72 to .80 in various studies for both adults and adolescents (Mahon & Yarcheski, 1994; Mahon, Yarcheski, & Yarcheski, 1997; Smith, 1997).

The content validity of the PLQ by Brown, Muhlenkamp, Fox, and Osborn (1983) was determined through a literature review which identified the most prevalent personal health behaviors. Concurrent validity with the Stevens' Point Lifestyle Questionnaire was adequate with resulting correlations ranging from .72 to .83 (Muhlenkamp & Brown, 1983). The PLQ was negatively correlated with the Health Hazard Appraisal (r = -.25) (Muhelnkanp & Brown, 1983).

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al., 2007)

Mental well-being, defined as a state in which an individual can optimize his/her abilities, can cope with life stresses, be productive, and contribute to his/her community

(WHO, 2011), was measured using the Warwick-Edinburgh Mental Well-being Scale (Tennant et al., 2007). The WEMWBS was developed to assess an individual's thoughts and feelings in the previous two weeks. This 14-item scale consists of positive affect, satisfying interpersonal relationships, and positive functioning with a 5-point Likert scale that ranges from one (none of the time) to five (all of the time). A higher total score indicates higher mental well-being. Example items are "I've been feeling cheerful" and "I've been interested in new things."

In a study with 348 students and 1749 members of the general public, internal consistency reliability was supported by good Cronbach's alphas ranging from .89 to .91 (Tennant et al., 2007). In the same study, a good test-retest reliability coefficient of .83 was found. A study of 1650 teenagers revealed a good Cronbach's alpha, .87, and an acceptable intra-class correlation coefficient for test-retest reliability, .66 (Clarke et al., 2011). Item total correlations were .51 to .80 in students and a general sample respectively (Tennant et al., 2007).

Construct validity was examined by confirmatory factor analysis, which revealed the WEMWBS has one-factor scale structure with over .5 in all items of factor loadings (Tennant et al., 2007). Tennant et al. (2007) indicated face validity of the WEMWBS was good because this scale covers various concepts associated with positive mental health (e.g., hedonic and eudaimonic aspects, positive affect, satisfying interpersonal relationships, and positive functioning). The WEMWBS was significantly correlated to positive affect (r = .71), depression-happiness (r = .73), psychological well-being (r = .74), and satisfaction with life (r = .73). It was negatively correlated to negative affect

(r = -.54) (Tennant et al., 2007). Tennant et al. (2007) showed good content validity by assessing the frequency of complete responses and the distribution of responses to each item.

Data Analysis

The Statistical Package for Social Science (SPSS) version 20.0 was used for data analysis with a .05 level of significance. Prior to data analysis, entry errors and missing values, as well as statistical assumptions, were checked to minimize biases. The accuracy of data entry was determined from two considerations. First, the double entry method, which includes entering all data twice and comparing the two entries, was used (Scott, Thompson, Wright-Thomas, Xu, & Barchard, 2008). Then, 10% of the data was randomly examined to confirm the accuracy of the data. Missing data was assessed. The amount of missing data was checked, with 5% of missing data as the cutoff (Schafer, 1999). The data of this study had less than 1% missing; the researcher used listwise deletion because any imputation or correction may be more likely to generate biases (Lynch, 2003).

The assumptions of each statistical method were checked prior to data analysis, including independency of the sample, normal distribution of variables (skewness, histograms, and normal probability plots), the homoscedasticity, and linearity. Additionally, descriptive statistics were used with means, standard deviations, range of scores, and frequencies to describe characteristics of participants for socio-demographic and immigration data and other variables; reliability for each instrument was checked.

To answer specific aims for research questions, the following analyses were performed:

Specific Aim 1: Explore the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S. and S. Korea

RQ 1. What are the relationships between socio-demographic factors, immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S.?

RQ 2. What are the relationships between socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in S. Korea?

Bivariate correlations were used to determine if two variables are linearly related, testing the relationships between variables to determine how strong or weak a relationship is (Huck, 2008). A bivariate analysis is essential for examining the theoretical model and developing a foundation for multivariate analysis (Brown, 2012). A correlation coefficient, *r*, is ranged between -1.00 and +1.00. A positive relationship means that one variable increases as the other variable increases, and a negative relationship means the inverse. The correlation coefficient represents ± .1 as a small effect, ± .3 as a medium effect, and ± .5 as a large effect (Field, 2009).

The Pearson correlation coefficient, *r*, measuring the relationship between continuous variables; and the Spearman rank order correlation coefficient, r_s, examining the relationship between two variables measured using ranked scores (e.g., family income and health status), were used depending on the level of measurement of variable. Prior to this data analysis, assumptions of correlation statistics were verified: independency of the sample, linear relationships between the variables, and normal distribution of the variables (Field, 2009).

Specific Aim 2: Explore the differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Koreans in the U.S. and in S. Korea.

> **RQ 3**. What are the differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Korean immigrants and Koreans in S. Korea?

Chi-square tests were applied for comparing dichotomous response variables, such as employment status and having health insurance, and for comparing ordinal variables between two independent groups, such as marital status, household size, education level, family income, and health status. Independent-sample t-tests assuming equal variances were employed for determining differences in the means and distributions of each of the two groups, Koreans in the U.S. and in S. Korea. The independent t-test compares two means when those means have come from different groups of entities and assumes

normally distributed data, an independency of the sample, and homogeneity of variance (Field, 2009).

Specific Aim 3: Identify the significant predictors of health-promoting behaviors and mental well-being for Koreans in the U.S. and in S. Korea

> **RQ 4**. What are the predictors among socio-demographic/immigration factors, acculturation, self-control, family functioning, and social resourcefulness of health-promoting behaviors and mental well-being for Koreans in the U.S.?
>
> **RQ 5**. What are the predictors among socio-demographic/immigration factors, acculturation, self-control, family functioning, and social resourcefulness of health-promoting behaviors and mental well-being for Koreans in S. Korea?

Hierarchical multiple regression analyses for identifying significant predictors of health-promoting behaviors and mental well-being were employed. Hierarchical multiple regression analysis is one type of multiple regression in which predictors are entered into the regression model in order (Field, 2009; Huck, 2008). Independent variables already proven to be predictors were entered first and newly examined variables were entered subsequently (Field, 2009). Prior to this data analysis, assumptions were verified: normality of error distribution, linearity of the relationship between dependent and independent variables, independence of errors, and homoscedasticity of errors.

The following four individual statistic procedures were assessed according to each research population (Koreans in the U.S. and in S. Korea) and two outcome variables (health-promoting behaviors and mental well-being);

First, to identify predictors of mental well-being among Koreans in the U.S., demographic factors including age, family income, health status, and English proficiency were placed in the first block; behavioral and cultural value acculturation were placed in the second block; self-control, family functioning, and social resourcefulness were placed in the third block; and health-promoting behaviors were placed in the last block.

Second, to identify predictors of health-promoting behaviors among Koreans in the U.S., demographic factors including age, family income, health status, and English proficiency were placed in the first block; acculturation was placed in the second block; self-control, family functioning, and social resourcefulness were placed in the last block.

Third, to identify predictors of mental well-being among Koreans in S. Korea, age, family income, and health status were placed in the first block; self-control, family functioning, and social resourcefulness were placed in the second block; and health-promoting behaviors were placed in the last block.

Lastly, to identify predictors of health-promoting behaviors among Koreans in S. Korea, age, family income, and health status were placed in the first block; and self-control, family functioning, and social resourcefulness were placed in the last block.

Specific Aim 4: Determine mediating effects of self-control, family functioning, and social resourcefulness on the relationship between acculturation and health-promoting behaviors and mental well-being among Koreans in the U.S.

> **RQ 6.** Do self-control, family functioning, and social resourcefulness mediate the relationships of acculturation on health-promoting behaviors and mental well-being among Koreans in the U.S.?

A mediator is a third explanatory variable that may influence the relationship between an independent variable and a dependent variable (Baron & Kenny, 1986). A mediator variable indicates how the relationship between an independent variable and a dependent variable occurs, and it is only tested when there is a significant relationship between the independent variable and the dependent variable.

Three regression equation analyses (Baron & Kenny, 1986) and the Sobel test (Preacher & Hayes, 2004) were applied to determine the mediating effects of self-control, family functioning, and social resourcefulness on the relationship between acculturation and health-promoting behaviors and mental well-being among Koreans in the U.S.

Three regression equations are needed in the analysis proposed by Baron and Kenny (1986) to check the direct and indirect effects of the independent variable on the dependent variable. First, regressing the mediator (self-control, family functioning, and social resourcefulness) on the independent variable (acculturation). Second, regressing the dependent variable (health-promoting behaviors and mental well-being) on the independent variable (acculturation). Third, regressing the dependent variable (health-

promoting behaviors and mental well-being) on both the independent variable (acculturation) and on the mediator (self-control, family functioning, and social resourcefulness). To establish the mediating effects, the following conditions must be met: the independent variable must affect the mediator in the first equation, the independent variable must affect the dependent variable in the second equation, and the mediator must affect the dependent variable in the third equation (Baron & Kenny, 1986).

To further assess the significance of the mediator, the Sobel test used a SPSS program developed by Preacher and Hayer (2004). If the mediator is a significant predictor of the dependent variable, or the direct relationship between the independent variable and dependent variable is less significant, a mediator effect exists in the model.

Pilot Study

In quantitative cross-cultural studies, it is important to select appropriate research instruments and translate them into the language of the target study population to ensure valid and reliable data. After translating an existing scale into another language, the researcher must confirm that the scale uses clear and appropriate language and psychometric properties before it is applied. Thus, a pilot study examines these issues (Johanson & Brooks, 2010).

Instruments for this study included the socio-demographic/immigration profile, the Korean American Acculturation Scale (Lee, 2004), the Brief Self-control Scale (Tangney et al., 2004), the Family Assessment Device-General Functioning (Epstein et al., 1993), the Social Resourcefulness Scale (Rapp et al., 1998), the Personal Lifestyle

Questionnaire (Muhlenkamp & Brown, 1983), and the Warwick-Edinburgh Mental Well-Being Scale (Tennant et al., 2006).

The socio-demographic/immigration profile was developed by the investigator in both Korean and English. The KAAS was originally developed by Lee (2004) in both English and Korean. The rest of the measures, including the BSCS, the FAD-GF, the SRS, the PRS, and the WEMWBS, were developed in English and were translated through an appropriate translation strategy that was followed by the investigator.

Drawn from a convenience sample of Korean immigrants, a pilot study using a cross-sectional descriptive design was conducted. The purpose of the pilot study was to test psychometric properties for use of the translated Korean instruments and to evaluate the overall research plan. The translated versions of instruments (the BSCS, the FAD-GF, the SRS, the PRS, and the WEMWBS) were tested for reliability on Korean immigrants through this pilot study.

Aim 1. To test the psychometric properties of the survey questionnaires

Aim 2. To estimate the time required for completing the survey questionnaires

Aim 3. To estimate the response rate

Aim 4. To evaluate the overall research plan

Translation of Instruments

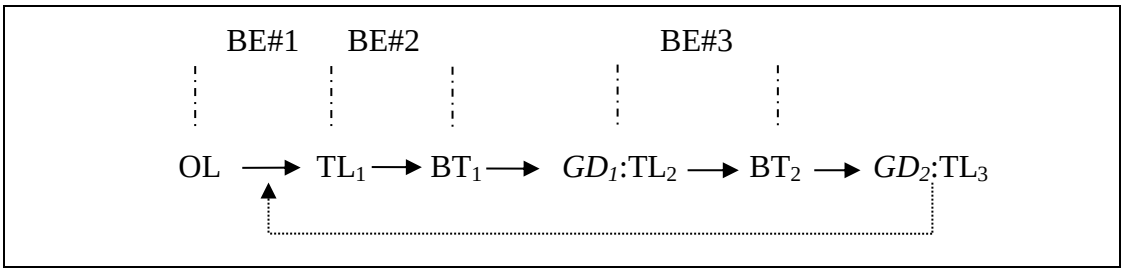
The translation strategy of this study emerged from Brislin's translation theory and the revised version suggested by Jones and his colleagues (Brislin, 1986; Jones, Lee, Phillips, Zhang, & Jaceldo, 2001) (Figure 3.1). After obtaining written permission from

the initial authors (APPENDIX E), the process to obtain the final Korean version of instruments for this study was conducted by three Korean-English bilingual experts.

First, the translation phase included direct translations, back-translations, and group discussions. The first Korean-English bilingual expert translated each instrument from the original language (English) into the target language (Korean) (TL_1). Next, a second Korean-English bilingual expert back-translated the Korean version into English without access to the original language version (BT_1). The two experts met with the investigator to review the back-translated instrument, check differences in meaning, and achieve consensus for the most accurate possible instruments (GD_1:TL_2). A third Korean-English bilingual expert blindly back-translated the new Korean version developed from the first group discussion into English (BT_2). A second group discussion with the three experts and the investigator was conducted in the same manner as the first group discussion, and then the most accurately translated instrument was agreed upon and obtained (GD_2:TL_3).

The investigator-designed iterative process of independent translation, blind back-translation, and following group discussion repeated until the back-translation achieved congruence of meaning between the original and target language instrument. Through the researcher's translation process, acceptable final translated instruments were obtained after one cycle and no repetitions were necessary in this study.

Figure 3.1. Emerged Modified Translation Strategy



BE: Bilingual Expert; OL: Original Language; TL: Translation; BT: Back-Translation; GD: Group Discussion

Sample in the Pilot Study

This pilot study to test the translated Korean questionnaires was administered to 30 Korean users among Koreans in the U.S. using a convenience sampling strategy. Inclusion criteria for this pilot study were as follows: (a) at least 18 years of age, (b) self-identify as a Korean immigrant, (c) able to read and write Korean, (d) residing in the U.S., and (e) willing to participate.

In this pilot study, Korean ethnic churches served as the major setting to recruit and gather data from the Korean immigrant population. The investigator posted flyers on the posting boards of Korean ethnic churches. Another way the investigator recruited participants was through personal acquaintances.

Procedures in the Pilot Study

The pilot study was approved by the Institutional Review Board of the University of Texas at Austin. Data collection for this pilot study took place from November 11 to December 5, 2012. The researcher initially contacted potential participants individually

or in groups, and those who met the inclusion criteria were invited to participate through personal contacts. The investigator explained the purpose and the participants' rights in the consent form for this study. If the potential participants agreed to participate in this study and signed the consent form, a copy of the consent form was given to each participant to keep. The rest of the data collection procedure was conducted in the same manner as the main study.

The instruments for this study consisted of eight self-report questionnaires including the Korean American Acculturation Scale. The KAAS already had both Korean and English versions, so it was used to describe the Korean immigrants' characteristics for the pilot study. Additionally, the instruments for the pilot study included two more questions to estimate the time required for completing the survey questionnaires and to find any problems completing this survey.

Analysis of the Pilot Study

The pilot study data was analyzed using the Statistical Package for the Social Sciences (SPSS) version 20.0. Data were evaluated and double entered to ensure accuracy. To describe the participants' characteristics and each variable, descriptive statistics including means and standard deviations for continuous variables, and frequencies and proportions for nominal data were applied.

To evaluate the psychometric properties of the translated instruments, reliability was examined with estimates of Cronbach's coefficient alphas, indicating item internal consistency. According to a commonly-accepted rule of thumb regarding coefficients, an

alpha of 0.6 to 0.7 indicates acceptable reliability, and 0.8 or higher indicates good reliability (Canada, 2011).

Findings in the Pilot Study

APPENDIX A shows demographic descriptive information for 30 participants in the pilot study. Thirty Korean immigrants completed the questionnaires for the pilot study. The average participant was 43.8 years of age (*SD* = 10.26), ranging from 19 to 67 years, women (63.3%), employed (66.7%), and had health insurance (70.0%). Fully 93.3% of the participants were married. A majority of participants had received college or higher degrees (63.3%). All participants lived with their families, ranging from one to five members (*Mean* = 3.1, *SD* = 1.06). Most participants reported self-health status as "I tend to be healthy" (80.0%). More than half of participants reported their family income as sufficient for essential needs for their family (60.0%).

A majority of participants reported they had lived in the U.S. for more than 10 years; the percentage of participants who came to the U.S. when they were older than 22 years was 83.3%. In terms of English usage, 20% of Korean participants never speak, but only 10% always speak English at home. English proficiency was examined to determine the extent of how well Koreans can speak English. The percentage of participants that answered very well was 16.7% and not at all was 10%. The self-reported range time required for completing questionnaires was 10 to 40 minutes (*M* = 21.33, *SD* = 8.1).

The mean of the behavioral KAAS was 62.0 (*SD* = 6.99) and ranged from 44 to 75, and the cultural value KAAS was 67.6 (*SD* = 5.95) and ranged from 57 to 81, which indicated that the acculturation levels were mostly low in this sample. The Cronbach's

alphas for the study measures were ranged from .73 to .88, which indicated acceptable to good reliablities in the pilot study. The summary of the entire psychometric properties in this pilot study is in Table 3.3. There were no missing items in the data. The average time required for completing questionnaires was about 25 minutes, determined from 30 participants.

Table 3.3. Psychometric Properties for the Pilot Study (N = 30)

	# of Item	**Possible Scale Range**	**Sample Scale Range**	***M***	***SD***	**Cronbach's *Alpha***
KAAS	33	33-165	108-155	129.7	9.16	.73
Behavioral	*15*	*15-75*	*44-75*	*62.0*	*6.99*	*.78*
Cultral Value	*18*	*18-90*	*57-81*	*67.6*	*5.95*	*.73*
BSCS	13	13-65	32-54	42.7	5.47	.73
FAD-GF	12	12-48	13-36	22.0	4.84	.84
SRS	20	0-80	26-63	42.4	9.33	.85
PLQ	23	24-96	52-87	64.0	8.90	.83
WEMWBS	14	14-70	35-66	50.8	7.99	.88

KAAS - Korean American Acculturation Scale; BSCS – Brief Self-Control Scale; FAD-GF – Family Assessment Device – General Functioning; SRS – Social Resourcefulness Scale; PLQ – Personal Lifestyle Questionnaire; WEMWBS - Warwick-Edinburgh Mental Well-Being Scale

Conclusions of the Pilot Study

The pilot study showed that the average age of the participants was approximately 44. Most of the participants were married and came to the U.S. after age 22. The majority of participants were employed, confident in their own health, had sufficient income for essential needs, and had health insurance. Most participants had lived for 10-14 years in the U.S. Participants scored low in the level of acculturation.

For psychometric properties, the pilot study showed satisfactory reliability for the Korean version of the BSCS, the FAD-GF, the SRS, the PLQ, and the WEMWBS instruments. Thus, the data from the pilot study provided an important first step for the main study in understanding Korean immigrants' lifestyles and well-being.

Protection of Human Subjects

Approval from the School of Nursing Departmental Review Committee and the Institutional Review Board of the University of Texas at Austin was obtained prior to conducting this study (APPENDIX B). After analyzing the pilot study, new IRB approval for the main study was obtained based on the advice of members of the dissertation committee. After obtaining IRB approval for the main study, an amendment for adding the trained Korean research assistant was approved. For the participants, the informed consent form in English or Korean depending on their preference was provided to clearly explain the purpose and procedures of the study including the rights of the participant, the protection of privacy and confidentiality, the risks and benefits of the study, and contact information (APPENDIX C). Participants had the right not to answer any questions and

to stop completing questionnaires at any point. All participants were reassured about the confidentiality and anonymity of all information provided by them.

The research assistant stored the completed surveys and signed consents in a secure filing cabinet until ready to mail to the investigator. The research assistant in S. Korea mailed the completed surveys and signed consents to the investigator through the certified mailing service - in separate mailings (consents in one mailing and surveys in another mailing).

To ensure confidentiality, code numbers were assigned to each individual questionnaire. The collected individual data was kept in a locked cabinet accessible only by the researcher to ensure that it was secure and remained confidential. The consent forms were separately stored from the data to avoid potential disclosure of the participants' identities. All data were identified with code numbers. The principal investigator has a private office with a locked file cabinet where study materials were stored. Additionally, the investigator has a computer that includes statistical support software that was used to conduct this study. The investigator transcribed the data to a SPSS file followed by the assigned code numbers, and only the investigator and the dissertation committee members handled that data. Further, officials at The University of Texas had the right to review any research data in the event of concerns.

Summary

This chapter describes the methods used in the study. A cross-sectional, comparative correlational design was applied to gain a more comprehensive understanding of Korean immigrants' transition to the U.S.

The target population of this study was Koreans in the U.S. and S. Korea, and a non-probability, convenience sampling strategy and a snowball sampling strategy were used. The data were collected from 192 Koreans (105 Korean immigrants and 87 native Koreans). The rationale for determining sample size was explained. Sampling and data collecting procedures were reviewed. Also, all eight instruments for the study have been reviewed. Through the pilot study with 30 Korean immigrants, the feasibility with reliabilities for the translated instruments was examined; it showed appropriate reliabilities for the translated Korean instruments.

CHAPTER 4: RESULTS

The purposes of this study were to describe health-promoting behaviors and well-being of Korean immigrants and to compare the health of Korean immigrants to the health of S. Koreans. This is a needed step in understanding the possible effects of the immigration transition process.

More specifically, the questions posed resulted in the following: (1) an examination of the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S. and S. Korea; (2) an exploration of the differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Koreans in the U.S. and in S. Korea; (3) an identification of the significant predictors of health-promoting behaviors and mental well-being for Koreans in the U.S. and S. Korea; and (4) the determination of mediating effects of self-control, family functioning, and social resourcefulness on the relationships between acculturation and health-promoting behaviors and mental well-being among Koreans in the U.S.

This chapter describes the following;

(1) Socio-demographic characteristics of Korean immigrants in the U.S. and Koreans in S. Korea

(2) Immigration information of Korean immigrants in the U.S.

(3) Examination of the research instruments

(4) Findings for each research question

Socio-Demographic Characteristics of the Sample

A total of 192 subjects, 105 Korean immigrants in the U.S. and 87 Koreans in S. Korea, participated in this study. A non-probability convenience sample of 105 Korean immigrants was recruited from Korean American communities in the U.S. Among the current data of Koreans in the U.S., 30 subjects for the pilot study were included. Through matched age and gender controls with Korean immigrants, 87 Koreans in S. Korea participated in the same manner as Koreans in the U.S.

The socio-demographic information for 105 Korean immigrants in the U.S. and 87 Koreans in S. Korea is described including age and gender, marital status and household size, level of education, working status and family income, and health insurance and current health status.

Age and Gender

The average age of 105 Korean immigrant participants in the U.S. was 46.8 (*Median* = 47, *SD* = 12.5) and ranged from 19 to 81 years and the average age of 87 S. Korea participants was 46.2 (*Median* = 46, *SD* = 12.7) and ranged from 18 to 79 years (Table 4.1). To match and collect Korean participants in S. Korea with Koreans in the U.S., age was divided into groups by decades. Approximately one third of the total participants were in their forties in both groups (32.4% and 34.5%).

For 105 Korean immigrants in the U.S., 64.8% females and 35.2% males were recruited. The percent of female Koreans in S. Korea was 66.7% and that of males was 33.3%, which was matched to the Korean immigrant sample in the U.S. Females

participated in this study more than males in both groups; approximately two times larger than male participants in both groups.

Table 4.1. Age and Gender for Koreans in the U.S. and S. Korea

	U.S. (***N* = 105**)	**Korea** (***N* = 87**)	**Total** (***N* = 192**)
	N (%)	***N (%)***	***N (%)***
Age	*M* = 46.8 *SD* = 12.5 Mode = 41, 42 Median = 47.0 Range = 19-81	*M* = 46.2 *SD* = 12.7 Mode = 45 Median = 46.0 Range = 18-79	*M* = 46.5 *SD* = 12.5 Mode = 42 Median = 46.0 Range = 18-81
18-30	9 (8.6%)	7 (8.0%)	16 (8.3%)
31-40	22 (21.0%)	19 (21.8%)	41 (21.4%)
41-50	34 (32.4%)	30 (34.5%)	64 (33.3%)
51-60	26 (24.8%)	19 (21.8%)	45 (23.4%)
61-70	10 (9.5%)	10 (11.5%)	20 (10.4%)
71 and Over	4 (3.8%)	2 (2.3%)	6 (3.1%)
Gender			
Male	37 (35.2%)	29 (33.3%)	66 (34.4%)
Female	68 (64.8%)	58 (66.7%)	126 (65.6%)

Marital Status and Household Size

The majority of participants in the U.S. and S. Korea were married (84.8% and 71.3%, respectively) (Table 4.2). Participants lived with their families in the U.S. ranging from one to eight members (*Median* = 3); in S. Korea ranging from one to seven members (*Median* = 4). The most common household size of Korean immigrants was three (33.3%), which seemed to have one couple and one child. On the other hand, the most common S. Koreans' household size was four (41.4%), which seemed to have one couple with two children. Koreans in the U.S. living alone without other family were ten times more common than Koreans in S. Korea (9.5% vs. 1.1%).

Table 4.2. Marital Status and Household Size for Koreans in the U.S. and S. Korea

	U.S. (***N* = 105**)	**Korea** (***N* = 87**)	**Total** (***N* = 192**)
	N (%)	***N (%)***	***N (%)***
Marital Status			
Married	89 (84.8%)	62 (71.3%)	151 (78.6%)
Divorced/Separated	3 (2.9%)	5 (5.7%)	8 (4.2%)
Widowed	3 (2.9%)	7 (8.0%)	10 (5.2%)
Single	10 (9.5%)	13 (14.9%)	23 (12.0%)
Household Size	*M* = 3.2 *SD* = 1.4 Mode = 3 Median =3 Range = 1-8	*M* = 3.9 *SD* = 1.1 Mode = 4 Median = 4 Range = 1-7	*M* = 3.5 *SD* = 1.3 Mode = 4 Median = 4.0 Range = 1-8
Alone	10 (9.5%)	1 (1.1%)	11 (5.7%)
2	21 (20.0%)	10 (11.5%)	31 (16.1%)
3	35 (33.3%)	17 (19.5%)	52 (27.1%)
4	20 (19.0%)	36 (41.4 %)	56 (29.2%)
5	13 (12.4%)	18 (20.7%)	31 (16.1%)
6	3 (2.9%)	3 (3.4%)	6 (3.1%)
7 and more	2 (1.9%)	1 (1.1%)	3 (1.5%)
(Missing)	1 (1.0%)	1 (1.1%)	2 (1.1%)

Attended Level of Education

Over half of participants in the U.S. and S. Korea had received college or higher degrees (64.8% and 58.6%, respectively) (Table 4.3). People who never attended grade school were 4.6% in S. Korea; but there was no Korean immigrant without any grade school education. The ratios of Korean immigrants in the U.S. who graduated elementary, middle, or high school were similar to those of Koreans in S. Korea. Korean immigrants in the U.S. who had received master's or doctoral degrees were approximately four times higher than Koreans in S. Korea (27.7% vs. 6.8%)

Table 4.3. Level of Education for Koreans in the U.S. and S. Korea

	U.S. (***N*** **= 105)**	**Korea** (***N*** **= 87)**	**Total** (***N*** **= 192)**
	N (%)	***N (%)***	***N (%)***
Less than High School Graduate	*9 (8.6%)*	*12 (13.8%)*	*21 (10.9%)*
Never Attended School	0 (0.0%)	4 (4.6%)	4 (2.1%)
Elementary Sch. Graduate	3 (2.9%)	2 (2.3%)	5 (2.6%)
Middle School Graduate	6 (5.7%)	6 (6.9%)	12 (6.3%)
High School Graduate	*28 (26.7%)*	*24 (27.6%)*	*52 (27.1%)*
Higher Education Degrees	*68 (64.8%)*	*51 (58.6%)*	*119 (62.0%)*
College Graduate	39 (37.1%)	45 (51.7%)	84 (43.8%)
Master's Degree Completed	22 (21.0%)	5 (5.7%)	27 (14.1%)
Doctoral Degree Completed	7 (6.7%)	1 (1.1%)	8 (4.2%)

Employment Status and Perceived Family Income Sufficiency

Over half of participants in the U.S. and S. Korea were employed (61.9% and 59.8%, respectively) (Table 4.4). Unemployed participants included housewives and retired people. Around one third of Korean participants in the U.S. and S. Korea reported their family income was insufficient or somewhat insufficient (26.7% and 39.0%, respectively). On the other hand, approximately two thirds of participants reported their family income as sufficient for essential needs for their family or more in both the U.S. and S. Korea (71.4% and 59.7%, respectively).

Table 4.4. Employment Status and Family Income for Koreans in the U.S. and S. Korea

	U.S. (*N* = 105)	**Korea (*N* = 87)**	**Total (*N* = 190)**
	N (%)	***N (%)***	***N (%)***
Employment Status			
Employed	65 (61.9%)	52 (59.8%)	117 (60.9%)
Unemployed	40 (38.1%)	35 (40.2%)	75 (39.1%)
Perceived Income Sufficiency			
Insufficient	*28 (26.7%)*	*34 (39.0%)*	*62 (32.3%)*
Insufficient for our Family	7 (6.7%)	11 (12.6%)	18 (9.4%)
Somewhat Insufficient	21 (20.0%)	23 (26.4%)	44 (22.9%)
Sufficient	*75 (71.4%)*	*52 (59.7%)*	*107 (66.1%)*
Sufficient for Essential Needs	56 (53.3%)	41 (47.1%)	97 (50.5%)
More than Sufficient	19 (18.1%)	11 (12.6%)	30 (15.6%)
(Missing)	2 (1.9%)	1 (1.1%)	3 (1.6%)

Health Insurance and Current Health Status

Korean immigrants in the U.S. who had health insurance were almost twice more than those who did not have health insurance (67.6% vs. 32.4%) (Table 4.5). S. Korea has a national health insurance system; but 4.6% of Koreans in S. Korea did not have health insurance. Many participants reported their self-health status as "I tend to be healthy" (75.2% and 64.4%, respectively); however, among participants who reported they were very unhealthy, 1.9% lived in the U.S. and 3.4% lived in S. Korea.

Table 4.5. Health Insurance and Health Status for Koreans in the U.S. and S. Korea

	U.S. (***N* = 105**)	**Korea** (***N* = 87**)	**Total** (***N* = 192**)
	N (%)	***N (%)***	***N (%)***
Health Insurance Status			
Yes	71 (67.6%)	83 (95.4%)	154 (80.2%)
No	34 (32.4%)	4 (4.6%)	38 (19.8%)
Current Health Status			
Very Unhealthy	2 (1.9%)	3 (3.4%)	5 (2.6%)
Unhealthy	14 (13.3%)	21 (24.1%)	35 (18.2%)
Healthy	79 (75.2%)	56 (64.4%)	135 (70.3%)
Very Healthy	10 (9.5%)	7 (8.0%)	17 (8.9%)

Immigration Information of Korean Immigrants in the U.S.

Immigration information was collected from 105 Korean immigrants in the U.S. Immigration information included length of stay in the U.S., age upon arrival to the U.S., English usage at home, and English proficiency.

Length of Stay in the U.S. and Age upon Arrival to the U.S.

Approximately one third of participants reported that they had lived in the U.S. for 10-14 years (31.4%) and a similar percentage said that they had lived in the U.S. for more than 20 years (29.5%) (Table 4.6). If the length of stay in the U.S. was less than 14 years, this means they immigrated to the U.S. after 2000. Thus, the percentage of immigrants who came in 2000 or later was 62.9%. The majority of participants came to the U.S. when they were older than 22 years (81.9%); however, one participant came to the U.S. before age 4.

Table 4.6. Length of Stay in the U.S. and Age upon Arrival to the U.S.

	N (%)		***N (%)***
Length of Stay in the U.S		***Age upon Arrival to the U.S.***	
Less than 1 year	1 (1.0%)		
1-2 years	9 (8.6%)	4 years old or less	1 (1.0%)
3-5 years	13 (12.4%)	5-11 years old	4 (3.8%)
6-9 years	10 (9.5%)	12-18 years old	6 (5.7%)
10-14 years	33 (31.4%)	19-22 years old	8 (7.6%)
15-19 years	8 (7.6%)	Older than 22 years old	86 (81.9%)
More than 20 years	31 (29.5%)		

English Usage at Home and Proficiency

In terms of English usage, 21.9% of Korean participants never speak, but only 10.5% always speak English at home (Table 4.7). Participants who reported always or frequently using English at home were defined as English users, and those who reported never, rarely, or sometimes were defined as Korean users. English speaking immigrants were approximately twice less likely to be Korean users (30.5% vs. 69.5%). English proficiency was examined to determine the extent of how well Koreans can speak English. The greatest percentage reported they can speak more than a few words of English (39.0%).The percentage of participants that answered very well was 9.5%; on the other hand, not at all was 6.7%. The population reporting limited English proficiency, which was defined as not speaking at all, speaking just a few words, and speaking more than a few words, was slightly over half of total immigrants (55.2%).

Table 4.7. English Usage and Proficiency for Koreans in the U.S.

	N (%)		***N (%)***
English Usage		***English Proficiency***	
Korean Users	*73 (69.5%)*	***Limited Proficiency***	*58 (55.2%)*
Never	23 (21.9%)	Not at all	7 (6.7%)
Rarely	30 (28.6%)	Just a few Words	10 (9.5%)
Sometimes	20 (19.0%)	More than a few Words	41 (39.0%)
English Users	*32 (30.5%)*	***English Proficiency***	*47 (44.7%)*
Usually	21 (20.0%)	Well	37 (35.2%)
Always	11 (10.5%)	Very Well	10 (9.5%)

Study Measures

Results for the study measures are described, including number of items, possible range of scale, sample scale range, mean, standard deviation, and *Cronbach's alpha*. The Korean American Acculturation Scale examined for Korean immigrants and other scales regarding self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being tested from both Koreans in the U.S. and in S. Korea.

The Korean American Acculturation Scale

The possible range of the total Korean American Acculturation Scale was from 33 to 165 with 33 items. The total mean score for the Korean American Acculturation Scale for the 105 first generation Korean immigrants was 128.2 (*SD* = 12.61) (Table 4.8).

Among the subscales of the Korean American Acculturaion Scale, the mean of behavioral acculturation was 60.5 (*SD* = 9.19) and the mean of cultural value acculturation was 68.0 (*SD* = 6.44). The *Cronbach's alphas* for the behavioral acculturation were .90, .81 for the cultural value acculturation, and .86 for the entire Korean American Acculturation Scale, which indicate that the reliabilities are good.

Table 4.8. Description of The Korean American Acculturation Scale

	# of Item	**Possible Scale Range**	**Sample Scale Range**	***M***	***SD***	***Cronbach's Alpha***
Behavioral Accul.	15	15-75	29-75	60.5	9.19	.90
Cultural value Accul.	18	18-90	41-88	68.0	6.44	.81
Total Acculturation	33	33-165	85-160	128.2	12.61	.86

The Brief Self-Control Scale

The mean score of self-control among the entire Korean group was 42.2 (*SD* = 6.02); 42.9 (*SD* = 5.83) for Korean immigrants; and 41.4 (*SD* = 6.18) for S. Koreans (Table 4.9). The possible scale range was from 13 to 65 with 13 items.

Acceptable *Cronbach's coefficient alphas* for the 13-item Brief Self-control Scale were equal to .75 for Koreans in the U.S., and .78 for Koreans in S. Korea. Also, *Cronbach's alpha* from all participants was acceptable, .77.

Table 4.9. Description of The Brief Self-Control Scale

	# of Item	**Possible Scale Range**	**Sample Scale Range**	***M***	***SD***	***Cronbach's Alpha***
U.S	13	13-65	26-57	42.9	5.83	.75
Korea			24-58	41.4	6.18	.78
Total			24-58	42.2	6.02	.77

The Family Assessment Device-General Functioning Scale

The mean score of general family functioning, in which the possible scale range was from 12 to 48 with 12 items, was 23.3 among both Korean groups (*SD* = 4.73); 23.0 for Korean immigrants *(SD* = 4.78); and 23.6 (*SD* = 4.68) for Koreans in S. Korea (Table 4.10).

Cronbach's coefficient alphas for the 12-item Family Assessment Device-General Functioning Scale were .88 for Korean immigrants, .87 for Koreans in S. Korea, and .87 for total Koreans, which indicate good reliabilities.

Table 4.10. Description of The Family Assessment Device-General Functioning Scale

	# of Item	**Possible Scale Range**	**Sample Scale Range**	***M***	***SD***	***Cronbach's Alpha***
U.S.	12	12-48	12-44	23.0	4.78	.88
Korea			12-36	23.6	4.68	.87
Total			12-44	23.3	4.73	.87

The Social Resourcefulness Scale

The possible scale range of the Social Resourcefulness Scale was from 0 to 80 with 20 items. The mean score of social resourcefulness among total Koreans was 42.6 (*SD* = 8.92); 42.3 (*SD* = 9.32) for Koreans in the U.S.; and 42.8 (*SD* = 8.46) for Koreans in S. Korea, (Table 4.11).

Cronbach's coefficient alphas for the 20-item Social Resourcefulness Scale were .84 for Koreans in the U.S., .81 for Koreans in S. Korea, and .83 for all participants, which according to commonly-accepted rules regarding reliability, indicate good reliabilities.

Table 4.11. Description of The Social Resourcefulness Scale

	# of Item	**Possible Scale Range**	**Sample Scale Range**	***M***	***SD***	***Cronbach's Alpha***
U.S.	20	0-80	24-63	42.3	9.32	.84
Korea			26-62	42.8	8.46	.81
Total			24-63	42.6	8.92	.83

The Personal Lifestyle Questionnaire

The mean score of health-promoting behaviors among both Korean groups was 66.9 (*SD* = 9.02); 68.9 (*SD* = 9.05) for Korean immigrants; and 64.6 (*SD* = 8.43) for S. Koreans (Table 4.12). The possible scale range was from 24 to 96.

Cronbach's coefficient alphas for the 24-item Personal Lifestyle Questionnaire were .81 for Korean immigrants, .79 for S. Koreans, and .80 for total participants, which indicate good reliabilities.

Table 4.12. Description of The Personal Lifestyle Questionnaire

	# of Item	**Possible Scale Range**	**Sample Scale Range**	***M***	***SD***	***Cronbach's Alpha***
U.S.	24	24-96	46-92	68.9	9.05	.81
Korea			45-84	64.6	8.43	.79
Total			45-92	66.9	9.02	.80

The Warwick-Edinburgh Mental Well-Being Scale

The mean score of mental well-being among both locations of Koreans was 51.1 (*SD* = 9.06); 51.6 (*SD* = 9.56) for Koreans in the U.S.; and 50.5 (*SD* = 8.42) for Koreans in S. Korea (Table 4.13). The possible scale range was from 14 to 70 with 14 items.

Cronbach's coefficient alphas for the 14-item Mental Well-Being Scale were .94 for Koreans in the U.S., .89 for Koreans in S. Korea, and .92 for total Koreans, which indicate good reliabilities.

Table 4.13. Description of The Mental Well-Being Scale

	# of Item	**Possible Scale Range**	**Sample Scale Range**	***M***	***SD***	***Cronbach's Alpha***
U.S.	14	14-70	23-70	51.6	9.56	.94
Korea			33-70	50.5	8.42	.89
Total			23-70	51.1	9.06	.92

Findings for Research Questions

Research Question 1.

What are the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S.?

Two types of correlation coefficients were applied to check relationships between two levels of measurement; Pearson product-moment for both interval levels of measurement; and Spearman rank for both ordinal levels. Family income, current health status, and English proficiency had ordinal levels of measurement; and age and other scale based scores had interval levels.

Prior to performing Pearson correlations, the assumptions for Pearson correlation, normality and linearity, were confirmed. The assumption of normality of the data was tested using histograms and Q-Q plots. Also, the assumption of normality was supported by the absolute value of skewness, less than 1.5 (Munro, 2005). Scatter plots were inspected to check linearity. The assumptions of normality and linearity for this data were met. Also, the independence of observation was supported by the data collection process since data were collected separately.

Table 4.14 presents correlations for the variables, selected in the analysis of regression, in Koreans in the U.S. using two types of correlation coefficients by their levels of measurement. The following sections described the relationships of each variable;

(1) The relationships between socio-demographic/immigration information variables and others.

(2) The relationships between acculturation and others.

(3) The relationships between self-control, family functioning, social resourcefulness, and others.

(4) The relationships between health-promoting behaviors, mental well-being, and others.

Relationships of Socio-Demographic/Immigration Information Variables

Age

Age was significantly correlated with family income (r = -.21, p < .05), current perceived health status (r = -.25, p < .05), and English proficiency (r = -.49, p < .01). Older Korean immigrants were less likely to be satisfied with family income, perceived poorer health status, and had poorer English proficiency than younger Korean immigrants. Age was significantly associated with behavioral acculturation (r = .23, p < .05) and social resourcefulness (r = -.25, p < .05). Older Korean immigrants were less acculturated in behavioral aspects and had less social resourcefulness than their younger counterparts.

Family income

Family income was significantly correlated with age (r = -.21, p < .05), health status (r_s = .32, p < .01), and English proficiency (r_s = .20, p < .05). Participants with better perceived family income were much more likely to be younger, have better health status, and have better English proficiency than those with poorer income. Family income was significantly correlated with family functioning (r = -.26, p < .01) and mental well-

being (r = .20, p < .05). Participants with higher reported family income showed better family functioning and higher mental well-being than their counterparts.

Current perceived health status

Current perceived health status was significantly correlated with age (r = -.25, p < .05), family income (r_s = .32, p < .01), and English proficiency (r_s = .26, p < .01). Participants having better current perceived health status were often younger, were more satisfied with family income, and had better English proficiency than those who had poor health status. Current perceived health status was significantly correlated with family functioning (r = -.24, p < .05). Participants having better current perceived health status had higher family functioning.

English proficiency

English proficiency was significantly correlated with age (r = -.49, p < .01), family income (r_s = .20, p < .05), and health status (r_s = .26, p < .01). Participants with better English proficiency showed to be younger, to have higher family incomes, and to have better health status. English proficiency was significantly correlated with behavioral acculturation (r = -.56, p < .01), family functioning (r = -.24, p < .05), social resourcefulness (r =.27, p < .01), and mental well-being (r = .30, p < .01). Participants with better English proficiency showed more behavioral acculturation, better family functioning, better social resourcefulness, and better mental well-being.

Relationships of Acculturation

Behavioral acculturation was significantly correlated with age (r = .23, p < .05). Korean immigrants with more behavioral acculturation were younger than those with less

acculturation. Behavioral acculturation was also significantly associated with English proficiency (r = -.56, p < .01). Korean immigrants with more behavioral acculturation had better English proficiency. Behavioral acculturation was significantly negatively associated with self-control (r = -.22, p < .05), which means highly acculturated Korean immigrants had more self-control.

Relationships of Self-control, Family Functioning, and Social Resourcefulness

Self-control

Self-control was significantly correlated with behavioral acculturation (r = -.22, p < .05), family functioning (r = -.33, p < .01), health-promoting behaviors (r = .22, p < .05), and mental well-being (r = .40, p < .01). Participants with greater self-control showed higher behavioral acculturation, better family functioning, better health-promoting behaviors, and better mental well-being.

Family functioning

Family functioning was significantly correlated with family income (r = -.26, p < .01), health status (r = -.24, p < .05), and English proficiency (r = -.24, p < .05). Korean immigrants who had better family functioning reported higher family income, better health status, and better English proficiency. Family functioning was significantly correlated with self-control (r = -.33, p < .01), social resourcefulness (r = -.20, p < .05), health-promoting behaviors (r = -.33, p < .01), and mental well-being (r = -.39, p < .01). Korean immigrants who had better family functioning showed greater self-control, better social resourcefulness, better health-promoting behaviors, and better mental well-being than those who had lower family functioning.

Social resourcefulness

Social resourcefulness was significantly correlated with age (r = -.25, p < .05) and English proficiency (r = .27, p < .01). Participants who had more social resourcefulness were younger and had higher English proficiency. Social resourcefulness was significantly correlated with family functioning (r = -.20, p < .05), health-promoting behaviors (r = .41, p < .01) and mental well-being (r = .44, p < .01). Participants who had more social resourcefulness had better family functioning, better health-promoting behaviors, and better mental well-being.

Relationships of Health-Promoting Behaviors and Mental Well-being

Health-promoting behaviors

Health-promoting behaviors were significantly correlated with self-control (r = .22, p < .05), family functioning (r = -.33, p < .01), social resourcefulness (r = .41, p < .01), and mental well-being (r = .49, p < .01). Korean immigrants who had better health-promoting behaviors had better self-control, better family functioning, more social resourcefulness, and better mental well-being.

Mental well-being

Mental well-being was significantly associated with family income (r = .20, p < .05) and English proficiency (r = .30, p < .01). Participants who had better mental well-being had greater family income and higher English proficiency than Korean immigrants who had lower mental well-being. Mental well-being was significantly associated with self-control (r = .40, p < .01), family functioning (r = -.39, p < .01), social resourcefulness (r = .44, p < .01), and health-promoting behaviors (r = .49, p < .01).

Korean immigrants who had better mental well-being had better self-control, better family functioning, more social resourcefulness, and better health-promoting behaviors than their counterparts.

Table 4.14. Correlations for Variables for Koreans in the U.S.

Variables	1	2	3	4	5	6	7	8	9	10	11
1. Age	1										
2. Family Income	-.21*	1									
3. Health Status	-.25*	.32**a	1								
4. English Proficiency	-.49**	.20*a	.26**a	1							
5. Behavioral Acculturation	.23*	-.02	-.06	-.56**	1						
6. Cultural Value Accul.	.15	-.06	-.11	-.10	.12	1					
7. Self-control	.11	.10	.12	.13	-.22*	.12	1				
8. Family Functioning	.17	-.26**	-.24*	-.24*	.02	-.02	-.33**	1			
9. Social Resourcefulness	-.25*	.14	.17	.27**	-.17	.05	.03	-.20*	1		
10. Health-Promoting Beh.	.08	.18	.16	.04	.13	.17	.22*	-.33**	.41**	1	
11. Mental Well-being	-.16	.20*	.19	.30**	-.17	.10	.40**	-.39**	.44**	.49**	1

* $p < .05$; ** $p < .01$; [a] Spearman rho (r_s)

Research Question 2.

What are the relationships between socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in S. Korea?

Prior to performing Pearson correlations, the assumptions for Pearson correlation, normality and linearity, were confirmed through inspecting histograms, Q-Q plots, and scatter plots. The assumptions were satisfied. Table 4.15 presents correlations for variables using the analysis of regression in Koreans in S. Korea. The following sections described the relationships of each variable;

(1) The relationships between socio-demographic variables and others.

(2) The relationships between self-control, family functioning, social resourcefulness, and others.

(3) The relationships between health promoting behaviors, mental well-being, and others.

Relationships of Socio-Demographic Variables

Age was significantly associated with social resourcefulness (r = -.37, p < .01) and mental well-being (r = -.21, p < .05). Older Koreans showed less social resourcefulness and worse mental well-being than younger Koreans. Family income was significantly correlated with family functioning (r = -.33, p < .01) and mental well-being (r = .26, p < .01). Koreans with more family income had better family functioning and better mental well-being than participants with less income. Health status was

significantly correlated with mental well-being (r = .21, p < .05). Koreans with better perceived health status showed better mental well-being than participants with poorer health status.

Relationships of Self-Control, Family Functioning, and Social Resourcefulness

Self-control was significantly correlated with health-promoting behaviors (r = .30, p < .01) and mental well-being (r = .29, p < .01). Koreans with greater self-control showed better health-promoting behaviors and mental well-being than participants with poorer self-control.

Family functioning was significantly correlated with family income (r = -.33, p < .01). Participants with higher family functioning had greater family income than those with lower functioning. Family functioning was significantly correlated with social resourcefulness (r = -.22, p < .05), health-promoting behaviors (r = -.23, p < .05), and mental well-being (r = -.26, p < .05). Participants with higher family functioning had higher social resourcefulness, greater health-promoting behaviors, and better mental well-being than those with low functioning.

Social resourcefulness was significantly correlated with age (r = -.37, p < .01). Koreans in S. Korea with higher social resourcefulness were younger than participants with lower resourcefulness. Also, social resourcefulness was significantly correlated with family functioning (r = -.22, p < .05), health-promoting behaviors (r = .31, p < .01), and mental well-being (r = .26, p < .05). Participants with higher social resourcefulness had higher family functioning, better health-promoting behaviors, and better mental well-being.

Relationships of Health-Promoting Behaviors and Mental Well-being

Health-promoting behaviors were significantly correlated with self-control (r = .30, p < .01), family functioning (r = -.23, p < .05), social resourcefulness (r = .31, p < .01), and mental well-being (r = .44, p < .01). Koreans with greater health-promoting behaviors showed better self-control, family functioning, social resourcefulness, and mental well-being.

Mental well-being was significantly correlated with age (r = -.21, p < .05), family income (r = .26, p < .01), and health status (r = .21, p < .05). Participants with better mental well-being were younger, had higher family income, and had better health status than their counterparts. Mental well-being was significantly correlated with self-control (r = .29, p < .01), family functioning (r = -.26, p < .05), social resourcefulness (r = .26, p < .05), and health-promoting behaviors (r = .44, p < .01). Participants with better mental well-being showed better self-control, better family functioning, better social resourcefulness, and greater health-promoting behaviors.

Table 4.15. Correlations for Variables for Koreans in S. Korea

Variables	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
1. Age	1							
2. Family Income	-.14	1						
3. Health Status	-.09	.14[a]	1					
4. Self-control	.03	.16	.07	1				
5. Family Functioning	.08	-.33**	.11	-.16	1			
6. Social Resourcefulness	-.37**	.20	.12	.04	-.22*	1		
7. Health-promoting Beh.	-.06	.14	.12	.30**	-.23*	.31**	1	
8. Mental Well-being	-.21*	.26**	.21*	.29**	-.26*	.26*	.44**	1

* $p < .05$; ** $p < .01$; [a] Spearman rho (r_s)

Research Question 3.

What are the differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Korean immigrants and Koreans in S. Korea?

RQ 3.1. What are the differences in **socio-demographic factors** between Korean immigrants and Koreans in S. Korea?

In order to compare the differences in socio-demographic factors between Koreans in the U.S. and in S. Korea, separate statistics were employed by the scale measure. Age and gender did not differ because Koreans in S. Korea were collected with matching age and gender to Koreans in the U.S. For parsimony, marital status and health status were divided into two levels (married and unmarried, unhealthy and healthy). The number of family members was divided into three levels, including 1-2, 3-4, and 5 or more.

Chi-square tests were applied for comparing dichotomous response variables, such as marital status, employment status, having health insurance, and health status, and for comparing ordinal variables between two independent groups, such as household size, education level, and family income.

Table 14.16 shows contingency tables and the results of chi-square tests. Chi-square tests of this distribution did not indicate a significant difference in employment status (χ^2 [1] = .091, p = .763); however, maritial status was different between U.S. and S. Koreans (χ^2 [1] = 5.161, p = .023). Married Korean immigrants were 84.8% and married S. Koreans were 71.3%. This distrubution did indicate a significant difference in having health insurance between Koreans in the U.S. and in S. Korea (χ^2 [1] = 23.135, p = .000). Koreans in S. Korea were significantly more likely to have health insurance than Koreans in the U.S. due to S. Korea having a national health insurance system (95.6% vs. 67.6%). Also, health status was different ((χ^2 [1] = 4.399, p = .036). Korean immigrants who reported they were healthy or very healthy were 84.8%, and native Koreans were 72.4%.

Table 4.16. Chi-square Tests for Difference in Dichotomous Variables Between Koreans in the U.S. and in S. Korea

Variables		***N (%)***		χ^2	***p***
		U.S.	**Korea**		
Marital Status	Married	89 (84.8%)	62 (71.3%)	5.161	.023
	Unmarried	16 (15.2%)	25 (28.7%)		
Employment Status	Employed	65 (61.9%)	52 (59.8%)	.091	.763
	Unemployed	40 (38.1%)	35 (40.2%)		
Health Insurance	Having Insurance	71 (67.6%)	83 (95.4%)	23.135	.000
	No Insurance	34 (32.4%)	4 (4.6%)		
Health Status	Unhealthy	16 (15.2%)	24 (27.6%)	4.399	.036
	Healthy	89 (84.8%)	63 (72.4%)		

Table 14.17 shows contingency tables and the results of chi-square tests for comparing household size, education level, and family income. Education level and perceived family income did not differ between Koreans in the U.S. and in S. Korea (*p*s > .05). However, household size was different (χ^2 [2] = 8.330, p = .016). The percentage of Korean immigrants who had 1-2 family members was 29.5%, but that of Koreans in S. Korea was 12.6%; 52.4% of Koreans in the U.S. and 60.9% of Koreans in S. Korea had 3-4 family members; 17.1% of Koreans in the U.S. and 25.3% of Koreans in S. Korea had 5 or more members. Thus, S. Koreans had a bigger family size than Koreans in the U.S.

Table 4.17. Chi-square Tests for Differences in Ordinal Variables Between Koreans in the U.S. and in S. Korea

Variables		***N***		χ^2	***p***
		U.S.	**Korea**		
Household Size	1-2	31 (29.5%)	11 (12.6%)	8.330	.016
	3-4	55 (52.4%)	53 (60.9%)		
	5 or more	18(17.1%)	22 (25.3%)		
Education Level	Less than High School Graduate	9(8.6%)	12 (13.8%)	1.490	.475
	High School Graduate	28 (26.7%)	24 (27.6%)		
	More than High School Grad.	68 (64.8%)	51 (58.6%)		
Family Income	Insufficient	7 (6.7%)	11 (12.6%)	3.935	.269
	Somewhat Insufficient	21 (20.0%)	23(26.4%)		
	Sufficient	56 (53.3%)	41 (47.1%)		
	More than Sufficient	19 (18.1%)	11 (12.6%)		

RQ 3.2. What are the differences in self-control, family functioning, and social resourcefulness between Korean immigrants and Koreans in S. Korea?

Prior to performing independent t-tests, the assumptions for t-tests were checked, such as normality and homogeneity. The assumption of normality of the data was satisfied from histograms and Q-Q plots. For the homogeneity assumption, Levene's tests for equality of variances were not significant (ps > .05), which indicated the homogeneity assumption was met.

Table 4.18 shows the results of independent t-tests for comparing differences in self-control, family functioning, and social resourcefulness between Korean immigrants and Koreans in S. Korea. The mean score of self-control between Koreans in the U.S. and Koreans in S. Korea was not significantly different (t [190] = 1.710, p = .089). However, the total mean score of self-control for Korean immigrants in the U.S. was 42.9 (SD = 5.83), which was slightly higher than that for Koreans in S. Korea (M = 41.4, SD = 6.18). The mean score of general family functioning between Koreans in the U.S. and Koreans in S. Korea was not significantly different (t [190] = -.819, p = .414); but Korean immigrants (M = 23.0, SD = 4.78) had marginally better family functioning than native Koreans (M = 23.6, SD = 4.68). The mean score of social resourcefulness was not significantly different (t [190] = -.470, p = .639), but Korean immigrants (M = 42.3, SD = 9.32) had slightly lower social resourcefulness than native Koreans (M = 42.8, SD = 8.46).

Table 4.18. T-tests for Differences in Self-control, Family Functioning, and Social Resourcefulness Between Koreans in the U.S. and S. Korea

Variables	**U.S.**		**Korea**		***t***	***df***	***p***
	M	***SD***	***M***	***SD***			
Self-control	42.9	5.83	41.4	6.18	1.710	190	.089
Family Functioning	23.0	4.78	23.6	4.68	-.819	190	.414
Social Resourcefulness	42.3	9.32	42.8	8.46	-.470	190	.639

RQ 3.3. What are the differences in health-promoting behaviors and mental well-being between Korean immigrants and Koreans in S. Korea?

Prior to performing independent t-tests, the assumptions for t-tests, normality and homogeneity, were confirmed. The assumption of normality of the data was met from histograms and Q-Q plots. The homogeneity assumption was met from the Levene's test for equality of variance.

Table 4.19 shows the results of independent t-tests for comparing differences in health-promoting behaviors and mental well-being between Korean immigrants and Koreans in S. Korea. The mean score of health-promoting behaviors for Koreans in the U.S. and Koreans in S. Korea differed significantly, t (190) = 3.387, p = .001. The total mean score of health-promoting behaviors for Korean immigrants in the U.S. was 68.9 (SD = 9.05), which was higher than that for Koreans in S. Korea (M = 64.6, SD = 8.43). To confirm which health-promoting behaviors were significantly different, specific subgroups were compared between Koreans in the U.S. and S. Korea. The subgroups of health promotion, safety, and substance use did not meet the assumption of homogeneity; the results of Levene's test for equality of variances were significant (ps < .05). Thus, the findings of these variables were used from the results that equal variances were not assumed. Korean participants in the U.S. showed statistically significantly higher levels in three subcategories, including health promotion, nutrition, and safety, than Koreans in S. Korea (ps < .05).

However, the mean of mental well-being for Koreans in the U.S. and Koreans in S. Korea did not differ significantly, t (190) = .818, p = .414, but Korean immigrants (M = 51.6, SD = 9.56) had slightly higher mental well-being than native Koreans (M = 50.5, SD = 8.42).

Table 4.19. T-tests for Differences in Health-promoting Behaviors and Mental Well-being Between Koreans in the U.S. and S. Korea

Variable	**U.S.**		**Korea**		***t***	***df***	***p***
	M	***SD***	***M***	***SD***			
Health-Promoting Behaviors	68.9	9.05	64.6	8.43	3.387	190	.001
Health Promotion	8.87	3.14	7.44	2.31	2.739	187.5	.007
Relaxation	13.95	2.50	13.95	2.73	-.004	190	.997
Nutrition	11.80	2.13	10.84	2.22	2.980	190	.003
Safety	13.20	1.67	11.60	2.19	5.575	158.5	.000
Substance Use	14.88	1.62	14.36	2.12	1.827	158.8	.070
Exercise	6.57	2.80	6.39	2.52	.495	190	.621
Mental Well-being	51.6	9.56	50.5	8.42	.818	190	.414

Research Question 4.

What are the significant predictors among socio-demographic/immigration factors, acculturation, self-control, family functioning, and social resourcefulness of health-promoting behaviors and mental well-being for Koreans in the U.S.?

Before performing the hierarchical regression analysis for Koreans in the U.S., assumptions for regression were tested such as normality, linearity, homoscedasticity, and independence. In order to confirm the normality assumption, histograms and Q-Q plots of residuals were tested; the assumption of normality of the data was satisfied from these histograms and Q-Q plots.

In order to examine linearity and homoscedasticity, scatter plots of the residuals against the predictors of dependent variables were tested. To meet the assumption of homoscedasticity, the residuals should distribute randomly around the line of zero (Osborne & Waters, 2002). In this study, the scatter plots of the residuals against the predicted dependent variables showed that the residuals randomly distributed; the assumption of homoscedasticity and linearity of the data were met.

To check the assumption of independent errors, the Durbin-Watson values of Studentized residuals were examined. The acceptable Durbin-Watson value was from 1.5 to 2.5 (Hutcheson & Sofroniou, 1999). In this study, the Durbin-Watson value was 1.973-2.141, in which the assumption of independency was supported.

To examine the presence of multicollinearity, the tolerances of variables and variable inflation factors (VIF) were checked. The tolerance of variables should be larger

than .1 to rule out the possibility of multicollinearity, and the cutoff point of VIF should be smaller than 10 (Belsley, Kuh, & Welsch, 1980; Kutner, Nachtsheim, & Neter, 2004). In this study, the tolerances of variables were all larger than .1, and ranged from .507 to .966, and the values of VIF were all smaller than 10, and ranged from 1.035 to 1.971, which indicated that multicollinearity was not evident in this current data.

RQ 4.1. What are the predictors among socio-demographic/immigration factors, acculturation, self-control, family functioning, and social resourcefulness of **health-promoting behaviors** for Koreans in the U.S.?

To identify predictors of health-promoting behaviors among Koreans in the U.S., demographic factors including age, family income, health status, and English proficiency were placed in the first block; behavioral and cultural value acculturation were placed in the second block; self-control, family functioning, and social resourcefulness were placed in the last block. Also, with the finding of the multiple hierarchical regression analysis, an additional regression was performed to get a parsimonious and predictive model.

Table 4.20 reports the results of the hierarchical regression for prediction of health-promoting behaviors in Koreans in the U.S. In Model 1, age, family income, current health status, and English proficiency accounted for 6.3% of the variation of health-promoting behaviors of Koreans in the U.S. Model 1 was not significant for predicting health-promoting behaviors (F [4, 98] = 1.647, p = .169). In Model 2, behavioral acculturation and cultural value acculturation provided 11.6% of explanation to Korean immigrants' health-promoting behaviors. Model 2 was also not significant for predicting health-promoting behaviors (F [6, 96] = 2.104, p = .060). Behavioral and cultural value acculturation did not have a significant regression coefficient (ps > .05). Lastly, in Model 3, self-control, family functioning, and social resourcefulness showed 35.0% of explanation to health-promoting behaviors (F [9, 93] = 5.566, p = .000). Self-control (t = 1.64, p = .104) did not have a significant regression coefficient, which was

excluded from the restricted regression model. However, family functioning (t = -2.09, p = .039) and social resourcefulness (t = 4.54, p = .000) had significant regression coefficients in predicting health-promoting behaviors. Also, behavioral acculturation had a marginally significant coefficient in Model 3 (t = 1.98, p = .050), so it was included in the restricted model. Thus, behavioral acculturation, family functioning, and social resourcefulness were left from the original model for predicting health-promoting behaviors of Koreans in the U.S.

An additional regression analysis for the restricted model was performed with behavioral acculturation, family functioning, and social resourcefulness, which excluded age, family income, health status, English proficiency, cultural value acculturation, and self-control. In the restricted model, behavioral acculturation, family functioning, and social resourcefulness explained 27.5% of the variation in Korean immigrants' health-promoting behaviors (F [3, 99] = 12.502, p = .000). The R^2 change from Model 3 (R^2 = .350) to the restricted model (R^2 = .275) was .075, and the F for testing the significance of this R^2 change was 1.797 (p = .108). Thus, the restricted model, which excluded the non-significant variables, did not show a significant change in R^2. As a result, behavioral acculturation, family functioning, and social resourcefulness were included in the restricted model for predicting Korean immigrants' health-promoting behaviors.

Table 4.20. Hierarchical Multiple Regression for Prediction of Health-Promoting Behaviors in Koreans in the U.S.

	Model 1				**Model 2**				**Model 3**				**Restricted Model**			
Variables	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***
Age	.01	.17	1.46	.147	.01	.15	1.37	.174	.01	.18	1.78	.079				
Family Income	.07	.15	1.46	.149	.07	.14	1.38	.171	.04	.07	.80	.426				
Health Status	.09	.14	1.25	.213	.09	.14	1.27	.207	.04	.05	.57	.572				
English Proficiency	.02	.05	.42	.679	.06	.16	1.18	.242	.02	.05	.38	.703				
	R^2 = .063															
Behavioral Accul.	F = 1.647, p = .169				.10	.17	1.48	.142	.13	.21	1.98	.050	.12	.20	2.25	.027
Cultural Value Accul.					.16	.17	1.74	.085	.09	.09	1.06	.291				
					R^2 = .116											
Self-control					F = 2.104, p = .060				.13	.16	1.64	.104				
Family Functioning					R^2 *change* = .053				-.19	-.20	-2.09	.039	-.26	-.27	-3.07	.003
Social Resourceful.					F *change* = 2.891,				.33	.41	4.54	.000	.31	.39	4.36	.000
					p = .060				R^2 = .350				R^2 = .275			
									F = 5.566, p = .000				F = 12.502, p = .000			
									R^2 *change* = .234				R^2 *change* = .075			
									F *change* = 11.155,				F *change* = 1.797,			
									p = .000				p = .108			

RQ 4.2. What are the predictors among socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, and health-promoting behaviors of **mental well-being** for Koreans in the U.S.?

To identify predictors of mental well-being among Koreans in the U.S., demographic factors including age, family income, health status, and English proficiency were placed in the first block; acculturation, behavioral and cultural value, was placed in the second block; self-control, family functioning, and social resourcefulness were placed in the third block; and health-promoting behaviors were placed in the last block.

Table 4.21 reports the results of the hierarchical multiple regression for predicting mental well-being among Koreans in the U.S. In Model 1, age, family income, current health status, and English proficiency accounted for 11.2% of the variation of mental well-being (F [4, 98] = 3.085, p = .019). Age, family income, and current health status did not have significant regression coefficients in predicting mental well-being (ps > .05); however, English proficiency had a significant coefficient (t = 2.32, p = .023). In Model 2, behavioral acculturation and cultural value acculturation added another 2.2% (R^2 *change*) of explanation to Korean immigrants' mental well-being (F [6, 96] = 2.475, p = .029). These acculturation variables, however, did not have significant regression coefficients (ps > .05). In Model 3, self-control, family functioning, and social resourcefulness added another 24.9% (R^2 *change*) of explanation to mental well-being (F [9, 93] = 6.424, p = .000). Self-control (t = 3.40, p = .001) and social resourcefulness (t = 4.01, p = .000) had significant regression coefficients in predicting mental well-being; however, family

functioning did not have a significant coefficient (t = -1.70, p = .093), so it was excluded from the regression model. Lastly, in Model 4, health-promoting behaviors added another 5.8% (R^2 *change*) of explanation to mental well-being (F [10, 92] = 7.275, p = .000). Health-promoting behaviors had a significant regression coefficient (t = 3.10, p = .003). As a result, self-control, social resourcefulness, and health-promoting behaviors were left in the model.

To achieve a predictive and parsimonious model, an additional regression analysis for the restricted model was performed that included self-control, social resourcefulness, and health-promoting behaviors with exclusion of age, family income, health status, English proficiency, behavioral and cultural value acculturation, and family functioning, which did not have significant coefficients. In the restricted model, self-control, social resourcefulness, and health-promoting behaviors explained 40.0% of the variation in Korean immigrants' mental well-being (F [3, 99] = 21.976, p = .000). The R^2 *change* from Model 4 (R^2 = .442) to the restricted model (R^2 = .400) was .042, and the F for testing the significance of this R^2 *change* was .985 (p = .447). Thus, the restricted model, which excluded the non-significant variables, did not show a significant change in R^2. As a result, self-control, social resourcefulness, and health-promoting behaviors were included in the restricted model for predicting Korean immigrants' mental well-being.

Table 4.21. Hierarchical Multiple Regression for Prediction of Mental Well-being in Koreans in the U.S.

	Model 1				**Model 2**				**Model 3**				**Model 4**				**Restricted Model**			
Variables	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***
Age	.00	.02	.21	.832	.00	.01	.05	.958	-.00	-.01	-.15	.883	-.00	-.07	-.71	.478				
Family Income	.10	.12	1.15	.254	.10	.12	1.19	.238	.04	.05	.55	.587	.02	.03	.31	.755				
Health Status	.11	.09	.84	.402	.13	.10	.97	.336	.01	.01	.12	.904	-.01	-.01	-.06	.956				
English Profic.	.17	.26	2.32	.023	.16	.24	1.82	.072	.09	.13	1.13	.262	.08	.12	1.06	.294				
	R^2 = .112																			
Behavioral A.	F = 3.085, p = .019				-.04	-.03	-.29	.776	.04	.04	.37	.711	-.03	-.03	-.24	.808				
Cultural Value A.					.26	.15	1.56	.122	.10	.06	.67	.505	.05	.03	-.36	.722				
					R^2 = .134															
Self-control					F = 2.475, p = .029				.48	.31	3.40	.001	.41	.27	2.98	.004	.49	.31	3.89	.000
Family Function					R^2 *change* = .022				-.27	-.16	-1.70	.093	-.17	-.10	-1.08	.285				
Social Resource.					*F change* = 1.226,				.51	.35	4.01	.000	.33	.23	2.48	.015	.44	.30	3.53	.001
					p = .298				R^2 = .383											
Health-promoting									F = 6.424, p = .000				.54	.30	3.10	.003	.53	.30	3.37	.001
									R^2 *change* = .249				R^2 = .442				R^2 = .400			
									F change = 12.537,				F = 7.275, p = .000				F = 21.976, p = .000			
									p = .000				R^2 *change* = .058				R^2 *change* = .042			
													F change = 9.593, p = .003				*F change* = .985, p = .447			

Research Question 5.

What are the significant predictors among socio-demographic factors, self-control, family functioning, and social resourcefulness of health-promoting behaviors and mental well-being for Koreans in S. Korea?

Before performing the hierarchical multiple regression analysis for Koreans in S. Korea, assumptions for regression were tested in the same manner as Koreans in the U.S., including normality, linearity, homoscedasticity, and independence. The assumption of normality of the data was satisfied from histograms and Q-Q plots. The assumption of homoscedasticity and linearity of the data were tested from scatter plots of the residuals. The Durbin-Watson value was 1.861 to 2.110, in which the assumption of independency was met. The tolerances of variables ranged from .741 to .980, and the values of VIF ranged from 1.021 to 1.350, which indicated that multicollinearity was not evident in the S. Koreans' data.

RQ 5.1. What are the predictors among socio-demographic factors, self-control, family functioning, and social resourcefulness of **health-promoting behaviors** for Koreans in S. Korea?

To identify predictors of health-promoting behaviors among Koreans in S. Korea, age, family income, and health status were placed in the first block; self-control, family functioning, and social resourcefulness were placed in the second block.

Table 4.22 reports the results of the regression for predicting health-promoting behaviors for Koreans in S. Korea. In Model 1, age, family income, and current health status accounted for 2.8% of the variation of health-promoting behaviors; however, this model did not explain the variation significantly (F [3, 82] = .773, p = .512). In Model 2, self-control, family functioning, and social resourcefulness added another 17.9% (R^2 *change*) of explanation to health-promoting behaviors (F [6, 79] = 3.429, p = .005). Self-control (t = 2.58, p = .012) and social resourcefulness (t = 2.59, p = .011) had significant regression coefficients in predicting health-promoting behaviors; however, family functioning did not show a significant coefficient (t = -1.24, p = .217), so it was excluded from the restricted model. As a result, self-control and social resourcefulness were left in the original model.

A regression analysis for the restricted model was performed with self-control and social resourcefulness. In the restricted model, self-control and social resourcefulness explained 18.6% of the variation in Koreans health-promoting behaviors (F [2, 83] = 9.461, p = .000). The R^2 *change* from the original model (R^2 = .207) to the restricted

model (R^2 = .186) was .021, and the F for testing the significance of this R^2 *change* was .522 (p = .720). Thus, the restricted model did not show a significant change in R^2. As a result, self-control and social resourcefulness were included in the restricted model for predicting S. Koreans' health-promoting behaviors.

Table 4.22. Hierarchical Multiple Regression for Prediction of Health-promoting Behaviors in Koreans in S. Korea

	Model 1				**Model 2**				**Restricted Model**			
Variables	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***
Age	-.00	-.03	-.28	.777	.00	.06	.53	.596				
Family Income	.05	.12	1.08	.283	-.01	-.01	-.11	.912				
Health Status	.05	.09	.81	.418	.04	.07	.68	.495				
	R^2 = .028											
Self-control	F = .773, p = .512				.20	.27	2.58	.012	.22	.29	2.95	.004
Family Functioning					-.12	-.14	-1.24	.217				
Social Resourcefulness					.24	.29	2.59	.011	.25	.31	3.08	.003
					R^2 = .207 F = 3.429, p = .005 R^2 *change* = .179 *F change* = 5.945, p = .001				R^2 = .186 F = 9.461, p = .000 R^2 *change* = .021 *F change* = .522, p = .720			

RQ 5.2. What are the predictors among socio-demographic factors, self-control, family functioning, and social resourcefulness of **mental well-being** for Koreans in S. Korea?

To identify predictors of mental well-being among Koreans in S. Korea, age, family income, and health status were placed in the first block; self-control, family functioning, and social resourcefulness were placed in the second block; and health-promoting behaviors were placed in the last block.

Table 4.23 reports the results of the regression for predicting mental well-being for Koreans in S. Korea. In Model 1, age, family income, and current health status accounted for 13.0% of the variation of Koreans' mental well-being (F [3, 82] = 4.090, p = .009). Age and health status did not have significant regression coefficients (ps > .05); however, family income showed a significant regression coefficient (t = 2.07, p = .042). In Model 2, self-control, family functioning, and social resourcefulness added another 10.9% (R^2 *change*) of explanation to mental well-being (F [6, 79] = 4.143, p = .001). Self-control had a significant regression coefficient (t = 2.34, p = .022); however, family functioning and social resourcefulness did not show significant regression coefficients (ps > .05). Lastly, in Model 3, health-promoting behaviors added another 8.0% (R^2 *change*) of explanation to mental well-being (F [7, 78] = 5.225, p = .000). Health-promoting behaviors had a significant regression coefficient (t = 3.03, p = .003). As a result, health-promoting behaviors were left in the original model for predicting S. Koreans' mental well-being.

An additional regression analysis for the restricted model was performed with health-promoting behaviors. The R^2 change from Model 3 (R^2 = .319) to the restricted model (R^2 = .194) was .125, and the *F* for testing the significance of this R^2 *change* was 2.385 (p = .036). Thus, the final restricted model showed a significant change in R^2. As a result, the full model was retained rather than the restricted model in predicting S. Koreans' mental well-being,

Table 4.23. Hierarchical Multiple Regression for Prediction of Mental Well-being in Koreans in S. Korea

	Model 1				**Model 2**				**Model 3**				**Restricted Model**			
Variables	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***	***B***	***β***	***t***	***p***
Age	-.01	-.17	-1.59	.116	-.01	-.13	-1.24	.218	-.01	-.15	-1.48	.142				
Family Income	.15	.22	2.07	.042	.07	.10	.94	.348	.07	.11	1.03	.306				
Health Status	.17	.18	1.69	.095	.17	.18	1.77	.081	.15	.16	1.62	.109				
	R^2 = .130															
Self-control	F = 4.090, p = .009				.30	.24	2.34	.022	.19	.15	1.51	.134				
Family Functioning					-.27	-.18	-1.62	.109	-.21	-.13	-1.27	.208				
Social Resourcefulness					.17	.12	1.06	.291	.03	.03	.23	.822				
					R^2 = .239											
Health-promoting behaviors					F = 4.143, p = .001				.54	.32	3.03	.003	.76	.44	4.50	.000
					R^2 *change* = .109				R^2 = .319				R^2 = .194			
					F change = 3.781, p = .014				F = 5.225, p = .000				F = 20.260, p = .000			
									R^2 *change* = .080				R^2 *change* = .125			
									F change = 9.148, p = .003				*F change* = 2.385, p = .036			
*p<.05; **p<.01																

Research Question 6.

Do self-control, family functioning, and social resourcefulness mediate the relationship of acculturation on health-promoting behaviors among Koreans in the U.S.?

According to the three equation model for identifying the mediating effect, Path 1 was examined to regress the mediator (self-control, family functioning, or social resourcefulness) on the independent variable (behavioral or cultural value acculturation). Path 2 was examined to regress the dependent variable (health-promoting behaviors or mental well-being) on the mediator (self-control, family functioning, or social resourcefulness). Path 3 was examined to regress the dependent variable (health-promoting behaviors or mental well-being) on both the independent variable (behavioral or cultural value acculturation) and the mediator (self-control, family functioning, or social resourcefulness). In order to have the total mediating effect, the independent variable should be significantly related to the mediator (Path 1); the mediator should be significantly related to the dependent variable (Path 2); and when Paths 1 and 2 are controlled, a previously significant relationship between the independent variable and the dependent variable should be changed to non-significant (Baron, & Kenny, 1986).

In addition, the Sobel tests (Preacher & Hayes, 2004) were checked to inspect the indirect effect of the independent variable (behavioral or cultural value acculturation) on the dependent variable (health-promoting behaviors or mental well-being) through the

mediator (self-control, family functioning, or social resourcefulness). In order to confirm the mediating effect, the result of the Sobel test should be significant ($p < .05$)

RQ 6.1. Does self-control mediate the relationship of behavioral or cultural value acculturation on health-promoting behaviors or mental well-being among Koreans in the U.S.?

Table 4.24 shows the results of three regression equations and the Sobel test to test the mediating effect of self-control. First, the results for identifying the mediating effect of self-control on the relationship between behavioral acculturation and health-promoting behaviors, showed that, for Path 1, behavioral acculturation was a significant predictor of self-control (F [1, 103] = 6.044, p = .016, β = -.235). For Path 2, self-control was a significant predictor of health-promoting behaviors (F [1, 103] = 5.305, p = .023, β = .221). The relationship between behavioral acculturation and health-promoting behaviors was not significant (F [1, 103] = 1.438, p = .233, β = .117). Path 3 with behavioral acculturation and self-control as predictors, showed that when Paths 1 and 2 are controlled, the relationship between behavioral acculturation and health-promoting behaviors was still non-significant (t = 1.835, p = .069, β = .179). As a result, self-control did not mediate the relationship between behavioral acculturation and health-promoting behaviors. This result was consistent with the result from the Sobel test, which showed that the indirect effect of behavioral acculturation on health-promoting behaviors through self-control was -.038 (Z = -1.752, p = .080).

Second, in order to test the mediating effect of self-control on the relationship between behavioral acculturation and mental well-being, the results showed that, for Path 1, behavioral acculturation was a significant predictor of self-control (F [1, 103] = 6.044,

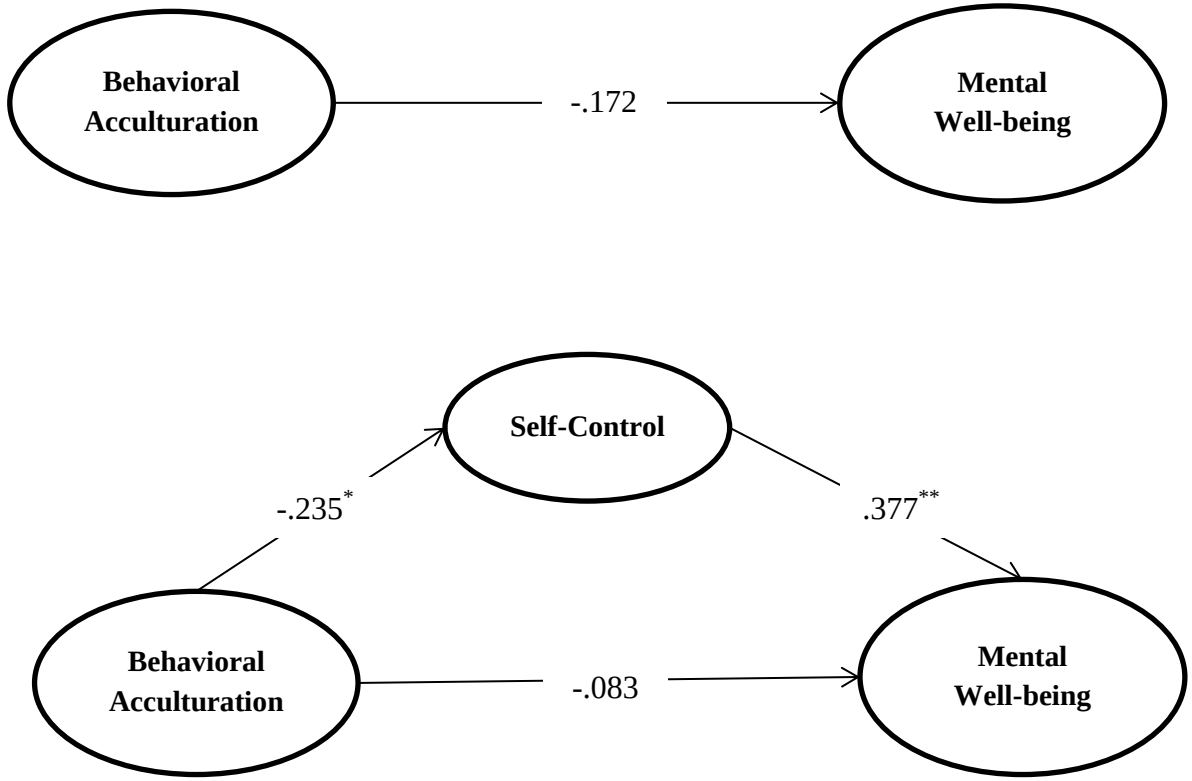
p = .016, β = -.235). In Path 2, self-control was significantly related to mental well-being (F [1, 103] = 19.258, p = .000, β = .397). The direct effect of behavioral acculturation on mental well-being was marginally significant (F [1, 103] = 3.140, p = .079, β = -.172). Path 3, with behavioral acculturation and self-control as predictors, showed that the relationship between behavioral acculturation and mental well-being was non-significant (t = -.893, p = .374, β = -.083). This result was confirmed by the Sobel test; the indirect effect of behavioral acculturation on mental well-being through self-control was -.099 (Z = -2.056, p = .040). As a result from three equation models and the Sobel test, self-control mediated the relationship between behavioral acculturation and mental well-being (Figure 4.1).

To test the mediating effect of self-control on the relationship between cultural value acculturation and health-promoting behaviors or mental well-being, Path 1 showed that the relationship between cultural value acculturation and self-control was not significant (p > .05). Thus, further study was not conducted. The Sobel test has a consistent result that the indirect effect was not significant (ps > .05). Thus, self-control did not mediate the relationship between cultural value acculturation and health-promoting behaviors or mental well-being.

Table 4.24. Testing the Mediating Effect of Self-Control

	Three Regression Equation Model							Sobel Test		
	R^2	*F*	*p*	*B*	*β*	*t*	*p*	*Value*	*z*	*p*
IV - Behavioral Acculturation, DV- Health-Promoting Behaviors										
Behavioral → Self-Control	.055	6.044	.016	-.172	-.235	-2.458	.016	-.038	-1.752	.080
Self-Control → Health Behav.	.049	5.305	.023	.186	.221	2.303	.023			
Behavioral → Health Behaviors	.014	1.438	.233	.072	.117	1.199	.233			
Behavioral, Self-Control → Health Behav	.079	4.397	.015	.110 .222	.179 .264	1.835 2.696	.069 .008			
IV - Behavioral Acculturation, DV- Mental Well-being										
Behavioral → Self-Control	.055	6.044	.016	-.172	-.235	-2.458	.016	-.099	-2.056	.040
Self-Control → Well-being	.158	19.258	.000	.604	.397	4.388	.000			
Behavioral → Well-being	.030	3.140	.079	-.192	-.172	-1.772	.079			
Behavioral, Self-Control → Well-being	.164	10.009	.000	-.093 .575	-.083 .377	-.893 4.051	.374 .000			
IV - Cultural Value Acculturation, DV- Health-Promoting Behaviors										
Cultural Value → Self-Control	.015	1.559	.215	.153	.122	1.249	.215	.026	.994	.320
Self-Control → Health Behaviors	.049	5.305	.023	.186	.221	2.303	.023			
Cultural Value → Health Behav.	.032	3.436	.067	.189	.180	1.854	.067			
Cultural Value, Self-Control → Health Behav	.073	3.995	.021	.163 .170	.155 .202	1.613 2.107	.110 .038			
IV - Cultural Value Acculturation, DV- Mental Well-being										
Cultural Value → Self-Control	.015	1.559	.215	.153	.122	1.249	.215	.092	1.170	.242
Self-Control → Well-being	.158	19.258	.000	.604	.397	4.388	.000			
Cultural Value → Well-being	.006	.657	.419	.152	.050	.811	.419			
Cultural Value, Self-Control → Well-being	.159	9.607	.000	.060 .599	.032 .393	.346 4.295	.730 .000			
IV – Independent Variable; DV – Dependent Variable										

Figure 4.1. The Mediating Effect of Self-Control on Mental Well-being (Standardized Coefficients, β)



RQ 6.2. Does **family functioning** mediate the relationship of behavioral or cultural value acculturation on health-promoting behaviors or mental well-being among Koreans in the U.S.?

Table 4.25 shows the results of three regression equations and the Sobel test to check the mediating effect of family functioning on the relationship between behavioral or cultural value acculturation and health-promoting behaviors or mental well-being. For Path 1, behavioral or cultural value acculturation was found not to be a significant predictor of family functioning (ps > .05). Thus, there were no further testings.

These results of three equations were consistent with the results from the Sobel test program, which showed that the indirect effects were not significant (ps > .05). As a result, family functioning did not mediate the relationships between behavioral or cultural value acculturation and health-promoting behaviors or mental well-being.

Table 4.24. Testing the Mediating Effect of Family Functioning

	Three Regression Equation Model							Sobel Test		
	R^2	*F*	*p*	*B*	*β*	*t*	*p*	*Value*	*z*	*p*
IV - Behavioral Acculturation, DV- Health-Promoting Behaviors										
Behavioral → Family Func.	.000	.014	.906	.008	.012	.119	.906	-.002	-.115	.909
Family Func. → Health Behav.	.111	12.844	.001	0.315	-.333	-3.584	.001			
Behavioral → Health Behaviors	.014	1.438	.233	.072	.117	1.199	.233			
Begavioral ↘ Health Behav	.126	7.324	.001	.075	.121	1.309	.195			
Family Func ↗				-.316	-.334	-3.611	.000			
IV - Behavioral Acculturation, DV- Mental Well-being										
Behavioral → Family Func.	.000	.014	.906	.008	.012	.119	.906	-.005	-.116	.908
Family Func. → Well-being	.150	18.137	.000	-.663	-.387	-4.259	.000			
Behavioral → Well-being	.030	3.140	.079	-.192	-.172	-1.772	.079			
Behavioral ↘ Well-being	.178	11.027	.000	-.187	-.167	-1.865	.065			
Family Func ↗				-.660	-.385	-4.288	.000			
IV - Cultural Value Acculturation, DV- Health-Promoting Behaviors										
Cultural Value → Family Func.	.000	.040	.841	.022	.020	.201	.841	-.007	-.194	.846
Family Func. → Health Behav.	.111	12.844	.001	0.315	-.333	-3.584	.001			
Cultural Value → Health Behav.	.032	3.436	.067	.189	.180	1.854	.067			
Cultural Value ↘ Health Behav	.146	8.690	.000	.196	.186	2.036	.044			
Family Func ↗				-.319	-.337	-3.678	.000			
IV - Behavioral Acculturation, DV- Mental Well-being										
Cultural Value → Family Func.	.000	.040	.841	.022	.020	.201	.841	-.015	-.196	.845
Family Func. → Well-being	.150	18.137	.000	-.663	-.387	-4.259	.000			
Cultural Value → Well-being	.006	.657	.419	.152	.050	.811	.419			
Cultural Value ↘ Well-being	.157	9.523	.000	.167	.087	.960	.339			
Family Func ↗				-.666	-.389	-4.275	.000			
IV – Independent Variable; DV – Dependent Variable										

RQ 6.3. Does **social resourcefulness** mediate the relationship of behavioral or cultural value acculturation on health-promoting behaviors or mental well-being among Koreans in the U.S.?

Table 4.26 shows the results of three regression equations and the Sobel test to examine the mediating effect of social resourcefulness. Every Path 1 showed that behavioral or cultural value acculturation was not a significant predictor of social resourcefulness (*p*s > .05). Thus, no further testings were conducted.

The Sobel test program showed that the indirect effects of behavioral or cultural value acculturation on health-promoting behaviors or mental well-being through social resourcefulness were not significant (*p*s > .05). As a result, social resourcefulness did not mediate the relationships between behavioral or cultural value acculturation and health-promoting behaviors or mental well-being.

Table 4.24. Testing the Mediating Effect of Social Resourcefulness

	Three Regression Equation Model							Sobel Test		
	R^2	*F*	*p*	*B*	*β*	*t*	*p*	*Value*	*z*	*p*
IV - Behavioral Acculturation, DV- Health-Promoting Behaviors										
Behavioral → Social Resour.	.030	3.157	.079	-.127	-.172	-1.777	.079	-.045	-1.642	.101
Social Resour. → Health Behav.	.164	20.251	.000	.328	.405	4.500	.000			
Behavioral → Health Behaviors	.017	1.801	.183	.078	.131	1.342	.183			
Behavioral Social Resour ↗ Health Behav	.206	13.228	.000	.123 .357	.207 .441	2.313 4.924	.023 .000			
IV - Behavioral Acculturation, DV- Mental Well-being										
Behavioral → Social Resour.	.030	3.157	.079	-.127	-.172	-1.777	.079	-.078	-1.628	.104
Social Resour. → Well-being	.189	24.045	.000	.638	.435	4.904	.000			
Behavioral → Well-being	.028	2.994	.087	-.181	-.168	-1.730	.087			
Behavioral Social Resour ↗ Well-being	.198	12.606	.000	-.103 .614	-.096 .419	-1.065 4.650	.289 .000			
IV - Cultural Value Acculturation, DV- Health-Promoting Behaviors										
Cultural Value → Social Resour.	.002	.206	.651	.052	.045	.454	.651	.017	.441	.660
Social Resour. → Health Behav.	.164	20.251	.000	.328	.405	4.500	.000			
Cultural Value → Health Behav.	.030	3.212	.076	.164	.174	1.792	.076			
Cultural Value Social Resour ↗ Health Behav	.189	11.857	.000	.147 .321	.156 .398	1.749 4.462	.083 .000			
IV - Behavioral Acculturation, DV- Mental Well-being										
Cultural Value → Social Resour.	.002	.206	.651	.052	.045	.454	.651	.033	.443	.658
Social Resour. → Well-being	.189	24.045	.000	.638	.435	4.904	.000			
Cultural Value → Well-being	.009	.927	.338	.161	.094	.963	.338			
Cultural Value Social Resour ↗ Well-being	.195	12.347	.000	.128 .633	.075 .432	.845 4.854	.400 .000			
IV – Independent Variable; DV – Dependent Variable										

Summary

This chapter describes the samples, study variables, and measures applied in this study. Then, the findings of each purpose were described. The level of acculturation of Korean immigrants in this study was low. Mental well-being was significantly associated with self-control, family functioning, social resourcefulness, and health-promoting behaviors for both Koreans in the U.S. and S. Korea. The score of health-promoting behaviors for Korean immigrants in the U.S. was slightly higher than that for Koreans in S. Korea, especially in health promotion, nutrition, and safety; however, other variables did not differ.

In the hierarchical multiple regression, behavioral acculturation, family functioning, and social resourcefulness predicted Korean immigrants' health-promoting behaviors; on the other hand, self-control and social resourcefulness predicted S. Koreans' behaviors. The predictors of Korean immigrants' mental well-being were self-control, social resourcefulness, and health-promoting behaviors, and S. Koreans' mental well-being predictor was health-promoting behaviors.

From the results of three equation models and Sobel tests, self-control mediated the relationship of behavioral acculturation on mental well-being among Koreans in the U.S.; however, this study did not find other mediating effects among Koreans in the U.S.

CHAPTER 5: DISCUSSIONS

This chapter summarizes the overall study, the participated sample, and the study measures. This chapter then discusses the findings by each research question and the conceptual framework based on the findings. Study implications for nursing practice, nursing research, and nursing education and theory are presented with recommendations for future research as well as the strengths and limitations of the study.

Study Summary

The primary purpose of this cross-sectional, comparative correlational design study was to explore the impacts of immigration transition on Koreans in the U.S. The specific aims were the following; this study proposed to examine the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S. and S. Korea. Second, this study aimed to compare differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Koreans in the U.S. and in S. Korea. Third, this study identified the significant predictors of health-promoting behaviors and mental well-being for Koreans in the U.S and in S. Korea. Finally, the researcher proposed to determine mediating effects of self-control, family functioning, and social resourcefulness on the relationship between acculturation and health-promoting behaviors and mental well-being among Koreans in the U.S.

To guide the study, the theoretical underpinning from transition theory was used (Meleis et al., 2000) (Figure 1.1). Three main domains for immigration transition - nature

of transition, transition conditions, and patterns of response - are explained. The properties of situational multiple transition for immigrants connect awareness, engagement, and change and difference to the new country. Transition conditions for immigrants mediate between transition properties and the indicators of healthy transition for facilitating or inhibiting health transitions (Meleis et al., 2000). Indicators of a healthy migration transition include embracing a sense of satisfaction, well-being, and mastery of skills and behaviors (Messias, 2010). This study explored the associations between the variables; the properties of transition operationalized as acculturation; transition conditions operationalized as self-control, family functioning, and social resourcefulness; and indicators of transition operationalized as health-promoting behaviors and mental well-being.

A total of 192 participants completed the survey; 105 Korean immigrants in the U.S. and 87 Koreans in S. Korea. Non-probability convenience sampling and snowball sampling strategies were used from Korean American communities in the U.S. Native S. Koreans were recruited from communities through matched age and gender controls with Korean immigrant participants in the U.S.

The initial target sample size was 154 (77 of each group), which was based on literature reviews and the result of a pilot study. After collecting data, the powers of this study with an effect size of .15, a sample size of 105 in the U.S. and 87 in S. Korea, and an *alpha* of .05, were .85 (S. Korea) and .95 (U.S.) from the G. Power.

The self-report paper-pencil questionnaire packages for Koreans in the U.S. included six instruments, as well as socio-demographic and immigration information

sheets; the Korean American Acculturation Scale (KAAS), the Brief Self-Control Scale (BSCS), the Family Assessment Device-General Functioning (FAD-GF), the Social Resourcefulness Scale (SRS), the Personal Lifestyle Questionnaire (PLQ), and the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS). All the questionnaires for Korean immigrants in the U.S. were in English or Korean depending on the participants' preferences. The questionnaire packages for Koreans in S. Korea excluded immigration information sheets and the KAAS.

The BSCS, the FAD-GF, the SRS, the PLQ, and the WEMWBS, which were developed in English, were translated through an appropriate translation strategy adapted from Brislin's translation theory and the revised version suggested by Jones and his colleagues (Brislin, 1986; Jones et al., 2001). The translated versions of instruments were tested for satisfactory reliability on Korean immigrants through a pilot study before their use in the current study.

Prior to data analysis using SPSS 20.0, to increase the accuracy of data entry, the double entry method and randomly examining 10% of the data were used. A listwise deletion was used due to the data of this study having less than 1% missing. Also, the assumptions of each statistical method were checked, including independency of the sample, normal distribution of variables, homoscedasticity, and linearity. Descriptive statistics were used to check means, standard deviations, range of scores, and frequencies as well as reliability for each instrument.

Bivariate correlations were used to determine how strong or weak a relationship was among variables. The independent t-tests compared two means between Koreans in

the U.S. and in S. Korea. Four individual hierarchical multiple regression analyses were used for identifying significant predictors of health-promoting behaviors and mental well-being in Koreans in the U.S. and in S. Korea. Moreover, three regression equation analyses were applied to determine the mediating effects of self-control, family functioning, and social resourcefulness on the relationships between acculturation and health-promoting behaviors and mental well-being among Koreans in the U.S. The Sobel tests then were applied to confirm the indirect effects on these relationships.

Discussions

Study Sample

Age and gender of Koreans in S. Korea had a similar distribution to those of Koreans in the U.S. since this study was an age and gender controlled study. The average age of 105 Korean immigrants was 46.8 (*SD* = 12.5) and the median age was 47 years; the average age of 87 S. Korea participants was 46.2 (*SD* = 12.7) and the median age was 46 years with almost one third being in their forties in both groups (32.4% and 34.5%). The medians of this study were slightly over the median ages, 40 to 45 years, of Korean American adults, all Asian American adults, and the national median in the 2010 American Community Survey (Pew Research, 2012).

Females who participated in this study outnumbered males in both groups (64.8% females and 35.2% males in the U.S.; 66.7% and 33.3% in S. Korea). This reflected that the number of Korean immigrant women was over half of the total Korean immigrants in the U.S. in 2008 (56.0% of women and 44.0% of men) (Terrazas & Batog, 2010). Other

studies focused on Korean immigrant adults had more women participants than men (Choi & Reed, 2013; Choi & Rush, 2012; Park, Cho, Park, Bernstein, & Shin, 2013).

The majority of participants in the U.S. and S. Korea were married (84.8% and 71.3%, respectively). The data of the 2010 American Community Survey reported that 56% of Korean Americans, 59% of all Asian Americans, and 51% of the national population were married. The most common household size of Korean immigrants in this study was three (33.3%), which was consistent with a study of 83 Korean Americans, indicating that the mean number of family members was 2.8 (Song et al., 2012).

The most commonly reported reason for Koreans immigrating to the U.S. is to pursue better educational opportunities and career options for themselves and/or their children since 2000 (Min, 2010). Their educational status is better than that of S. Koreans and other comparable groups. Over half of the participants in the U.S. and S. Korea had received college or higher degrees (64.8% and 58.6%, respectively) (Table 4.3). Korean immigrants in the U.S. who had received master's or doctoral degrees were four times higher than Koreans in S. Korea (27.7% vs. 6.8%). According to the 2008 and 2010 national data, slightly over half of all Korean immigrants had received college or higher degrees (51.0% and 53%) (Pew Research, 2012; Terrazas & Batog, 2010). Korean immigrants and S. Koreans in the current study were better educated compared to a national study; 51.0% of Korean immigrants, 27.1% of all U.S. immigrants, and 27.8% of all U.S. native populations had received college or higher degrees (Terrazas & Batog, 2010).

Around one third of participants reported their family income as insufficient for

essential needs or insufficient for their family in both the U.S. and S. Korea; Koreans in the U.S. were less likely to perceive insufficient family income than Koreans in S. Korea (26.7% vs. 39.0%, respectively). This current study measured perceived family income sufficiency, but national data defined poverty as having a total annual income below 200% of the federal poverty line in 2008 national data. It reported that 26.2% of Korean immigrants were in poverty, compared to 37.9% of total U.S. immigrants and 28.7% of the total native born reported to be in poverty (Terrazas & Batog, 2010).

Korean immigrants in the U.S. who did not have health insurance were 32.4% in the current study, but 4.6% of Koreans in S. Korea did not have health insurance. A study comparing Korean Americans and Koreans in S. Korea reported 64.2% to 87.5% of Korean Americans had health insurance, but 98.4% of S. Koreans had health insurance because of a requirement by the Korean government (Song et al., 2004). In the national data, over one fourth of Korean immigrants did not have health insurance in 2008 (27.5%), which was a smaller percentage than the total of U.S. immigrants (32.9%) but more than U.S. native citizens (12.9%) (Terrazas & Batog, 2010).

Many participants reported their self-health status as "I tend to be healthy" (75.2% and 64.4%, respectively); however, participants who reported they are very unhealthy were 1.9% in the U.S. and 3.4% in S. Korea. In a study of 356 Korean Americans, 85.6% reported good or excellent health and 14% poor or fair perceived health (Lee, Sobalb, & Frongillo, 2000), and Sin et al. (2010) reported 13.6% of Korean immigrants and 14.6% of native Koreans perceived their health to be poor. Comparing the two studies with this

study (Lee, Sobalb, & Frongillo, 2000; Sin et al., 2010), participants in the current study had better health.

According to the 2008 national data, about one third of Korean immigrants came to the U.S. in 2000 or later (27.9%). However, in the current data, approximately two thirds of Korean immigrants had lived in the U.S. for less than 14 years, which means they entered after 2000 (62.9%) (Terrazas & Batog, 2010). In this study, the percentage of Korean immigrants living over 10 years in the U.S. was 68.5%, otherwise, 56.7% or 85.8% were reported from the previous studies (Bernstein, Park, Shin, Cho, & Park, 2011; Han, Kim, Lee, Pistulka, & Kim, 2007). From the study of Ayers et al. (2009), the average length of stay in the U.S. for 591 Korean immigrant women was 17.4 years (*SD* = 10.07).

In terms of English usage, 69.5% of Korean participants have spoken Korean at home, but only 30.5% always or usually have spoken English at home in the current study. English-using Korean immigrants were higher than the data from the Asian American studies program (73.5% and 19.5% of Korean and English users) (Asian American Studies Program [AASP], 2011).

More than half of Korean immigrants reported limited English proficiency, speaking less than "more than a few words" in the current study (55.2%). It was slightly lower than data from the 2010 American Community Survey, in which about 46% of Korean immigrant adults aged 18 and older reported limited English proficiency (Pew Research, 2012; Terrazas & Batog, 2010). In the current data, only 9.5% of first generation Korean immigrants reported high proficiency in English. It was slightly lower

than the finding of the Asian American Studies Program, in which 12.6% reported speaking English fluently (AASP, 2011). Also, a study of 304 Korean immigrants indicated approximately 80% of participants reported limited English speaking (Bernstein et al., 2011). Thus, Korean immigrants in this study showed a relatively limited English proficiency.

Study Measures

Table 5.1 summarizes sample scale range, mean, standard deviation, and Cronbach's alpha for each study measure. According to the findings about the Korean American Acculturation Scale in the current study, the mean of behavioral acculturation was 60.5 (*SD* = 9.19) and the mean of cultural value acculturation was 68.0 (*SD* = 6.44). A similar finding was found in a study about 376 first generation Korean immigrants in age from 35 to 60 years, behavioral acculturation (*M* = 62.1, *SD* =7.65) and cultural value acculturation (*M* = 69.8, *SD* = 6.84) (Park, 2010). A higher score means a lower degree of acculturation. The acculturation level of Korean immigrants was low; the same finding was revealed in the study of Park (2010) using the same acculturation measure, the Korean American Acculturation Scale. Although different instruments measured acculturation, other studies also reported Korean immigrants had low or moderate acculturation levels (Choi & Rankin, 2009; Jasti, Lee, & Doak, 2011; Yang, 2005). That is, Koreans tend to prefer maintaining Korean culture and previous behaviors rather than integrating or assimilating to American culture (Park, 2010). According to the 2012 Asian-American survey, Korean Americans were likely to be more strongly connected to Korean ethnic communities across U.S. Asian groups. The acceptable Cronbach's alphas

were reported for the Korean American Acculturation Scale in the current study, .90 for behavioral acculturation, .81 for cultural value acculturation, and .86 for the overall Korean American Acculturation Scale. These satisfactory reliabilities were found in the existing studies, .82 to .92 for behavioral acculturation and .70 to .82 for cultural value acculturation (Lee, 2003, 2004; Park, 2010).

Tangney et al. (2004) defined that higher total scores in the Brief Self-control Scale indicate greater self-control, with a possible range from 13 to 65. The mean scores of self-control among the current Korean groups were 41.4 to 42.9 (*SD* = 5.83-6.18). Similar mean scores for the Brief Self-control Scale were reported in other studies; from 39.2 to 39.9 (*SD* = 8.58-8.61), and scores ranging from 15 to 63 among undergraduate students (Tangney et al., 2004). In another study on students, the mean score was 42.0 to 44.0 (*SD* = 7.09-7.19) (Schmeichel & Zell, 2007). Although the focused participants differed, Korean immigrants had a similar mean score, not over or below, to other populations in the level of self-control. In the current study, acceptable Cronbach's coefficient alphas for the 13-item Brief Self-control Scale were equal to .75 to .78 for Koreans in the U.S. and in S. Korea. The studies on other populations, such as undergraduate students and incarcerated offenders, reported satisfactory alphas, .81 to .88 (De Ridder et al., 2011; Duckworth et al., 2007; Mathews et al., 2007; Tangney et al., 2004).

The mean scores of general family functioning from the current study, in which the possible scale range was from 12 to 48 with 12 items, were 23.0 to 23.6 (*SD* = 4.68-4.78) in the current study. Epstein et al. (1983) defined that lower scores indicate higher

healthy family adjustment and higher scores, 24.00 or above, indicate problematic family functioning (Morse, 2011). The mean scores in the previous studies were from 22.1 to 29.2 (Gaitor, 2011; Kabacoff et al, 1990) and in the study on Arab Muslim immigrants in the U.S., the mean score of general family functioning was 26.9 (*SD* = 5.52) (Willems, 2012). The score for Koreans in the current study was slightly better in family functioning compared to the previous studies. Cronbach's coefficient alphas for the 12-item Family Assessment Device-General Functioning Scale in the current study were acceptable, .88 for Korean immigrants and .87 for Koreans in S. Korea. These satisfactory results were found in several previous studies, ranging from .83 to .92 (Epstein et al., 1983; Kabacoff et al., 1990; Musil et al., 2006; Saied, 2006).

The average mean scores of social resourcefulness were 42.3 to 42.8 (*SD* = 8.46-9.32) for U.S. Koreans and S. Koreans, ranging from 24 to 63. In the previous studies, the mean scores ranged from 53.4 to 62.5 (Olveros, 2007; Rapp et al., 1998). Rapp et al. (1998) defined that higher scores indicate a greater level of social resourcefulness. Compared to the previous studies, Koreans in this study had a limited level of social resourcefulness. Cronbach's coefficient alphas for the 20-item Social Resourcefulness Scale were acceptable in the current study, .84 for Koreans in the U.S. and .81 for Koreans in S. Korea, which was consistent with the existing studies, in which the values were .85 (Rapp et al., 1998) and .82 (Oliveros, 2007).

In the health-promoting behaviors scale, the mean scores were 64.6 to 68.9 (*SD* = 8.43-9.05) for Koreans in this study. The mean scores were 70.4 to 71.0 from the studies for 244 elders and 202 adults (McNicholas, 2002; Scott & Jacks, 2000), which indicated

a relatively high practice of health-promoting activities. On the other hand, in the study for 392 undergraduate students, the mean score was low, 48.5 (Christensen, Moran, & Wiebe, 1999). Thus, Koreans had relatively acceptable scores for health-promoting behaviors compared to previous studies. Cronbach's coefficient alphas for the 24-item Personal Lifestyle Questionnaire were .81 for Korean immigrants and .79 for S. Koreans. These acceptable reliabilities were found in several studies, ranging from .72 to .80 (Mahon et al., 2002; Mahon & Yarcheski, 1994; Mahon et al., 1997; Muhlenkamp & Brown, 1983; Smith, 1997).

The mean scores of mental well-being among Koreans were 50.5 and 51.6 (*SD* = 8.42-9.56) in this study, which were compared to previous studies; 48.8 to 50.2 for teenagers or undergraduate students (Clarke et al., 2011; Davoren, Fitzgerald, Shiely, & Perry, 2013). A higher score indicates higher mental well-being. Koreans in this study had marginally better mental well-being compared to previous studies. Cronbach's coefficient alphas for the 14-item Mental Well-Being Scale were .94 for Koreans in the U.S. and .89 for Koreans in S. Korea, which indicate good reliabilities. This finding was supported by previous studies, with good Cronbach's alphas ranging from .87 to .91 (Clarke et al., 2011; Tennant et al., 2007).

Table 5.1. Descriptions of Study Measures

	U.S.				Korea				Total			
	Range[a]	***M***	***SD***	**Alpha**	**Range**[a]	***M***	***SD***	**Alpha**	**Range**[a]	***M***	***SD***	**Alpha**
KAAS	85-160	128.2	12.61	.86								
Behavioral	29-75	60.5	9.19	.90								
Cultural Value	41-88	68.0	6.44	.81								
BSCS	26-57	42.9	5.83	.75	24-58	41.4	6.18	.78	24-58	42.2	6.02	.77
FAD-GF	12-44	23.0	4.78	.88	12-36	23.6	4.68	.87	12-44	23.3	4.73	.87
SRS	24-63	43.3	9.32	.84	26-62	42.8	8.46	.81	24-63	42.6	8.92	.83
PLQ	46-92	68.9	9.05	.81	45-84	64.6	8.43	.79	45-92	66.9	9.02	.80
WEMWBS	23-70	51.6	9.56	.94	33-70	50.5	8.42	.89	23-70	51.1	9.06	.92

[a] Sample Scale Range

Findings Regarding Research Questions

Research Question 1.

What are the relationships between socio-demographic/immigration factors, acculturation, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in the U.S.?

Research Question 2.

What are the relationships between socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being among Koreans in S. Korea?

Behavioral acculturation was significantly correlated with age (r = .23, p < .05) and English proficiency (r = -.56, p < .01) among Korean immigrants. A lower score of acculturation means a higher degree of acculturation. Thus, younger Korean immigrants or immigrants who had better English proficiency were more behaviorally acculturated than their counterparts. Age was associated with level of acculturation in several previous studies (Ayers et al., 2009; Jang & Chriboga, 2007; Jang, Kim, & Chiriboga, 2005; Jasti, Lee, & Doak, 2011; Kim, & Chan, 2004; Song et al., 2004). Jasti and colleagues' study showed people under the age of 28 were more acculturated than people over the age of 28 (Jasti, Lee, & Doak, 2011). A negative relationship between age and acculturative stress was reported among 304 Korean immigrants (Bernstein et al., 2011). However, some other studies reported no relationship between age and acculturation (Choi, Miller, & Wilbur, 2009; Kim, 2007; Lee, Koeske, & Sales, 2004; Park et al., 2003) or between age

and acculturative stress (Han et al., 2007; Shin, Han, & Kim, 2007). In other studies, younger age at immigration, rather than current age, led immigrants to be more acculturated (Choi, Miller, & Wilbur, 2009; Jasti et al., 2011; Lee, 2007).

Behavioral acculturation was significantly negatively associated with self-control (r = -.22, p < .05), which means highly acculturated Korean immigrants had more self-control in this study. A previous study for Mexican Americans revealed that the relationship between language acculturation and personal control was positive; more language acculturated participants were more likely to have greater personal control (Krause, Bennett, & Tran, 1989).

Acculturation was not related to mental health among Korean immigrants in this study (p > .05); similar findings were reported among both community dwelling Korean immigrant elderly and Korean elderly (Sin, Choe, Kim, Chae, & Jeon, 2010), and among Mexican Americans (Krause, Bennett, & Tran, 1989). However, in other studies of various ethnic groups, Hispanic, Mexican, or Asian Indians as well as Korean immigrants, higher acculturation was associated with better mental health (Ayers et al., 2009; Cuellar et al., 2004; Escalanta et al., 2000; Heilemann et al., 2004; Mehta, 1997). Lim, Yi, and Zebrack (2008) showed that higher acculturation was associated with lower depression, which in turn leads to better quality of overall life. In the current study, acculturation was not related to health-promoting activities (p > .05), but some studies showed reversed findings; the relationship between acculturation and smoking was important in Korean immigrant women (Lee, Sobal, & Frongillo, 2000) and acculturation was positively

related to Hispanic adolescents' substance use behaviors (Pokhrel, Herzog, Sun, Rohrbach, & Sussman, 2013).

The relationship between mental well-being and family income was significant in both Koreans in the U.S. and in S. Korea (r = .20 and r = .26, ps < .05); additionally for S. Koreans, mental well-being was significantly correlated with age (r = -.21, p < .05) and health status (r = .21, p < .05). Both indicated participants who had greater family income had better mental well-being. Low income was associated with more acute stressful life events and poor mental health (Hammen, 2005; Maisel & Karney, 2012; McLeod & Kessler, 1990). Also, quality of life was related to family income (Hsiao, Hsieh, Tseng, Chien, & Chang, 2012). Studies of Korean immigrants reported that income was related to happiness and depression (Kim, Seo, & Cain, 2010; Sin, Han, & Kim, 2007). However, 95 elderly Korean immigrants reported that mental health did not correlate to income (Lee, Moon, & Knight, 2004).

S. Korean participants with better mental well-being in the current study were younger than their counterparts. Among women in a study using the same measure of mental well-being, the Warwick-Edinburgh Mental Well-Being Scale, age was related to women's mental well-being, but was not significant for men (Davoren, Fitzgerald, Shiely, & Perry, 2013). A study of 147 Korean immigrants reported that age was associated with happiness and depression (Shin, Han, & Kim, 2007) and a study of 592 Korean immigrant women reported age was significantly associated with depression (Ayers et al., 2009). On the other hand, other studies showed no relationship between age and mental

health (Bernstein et al., 2011; Han et al., 2007; Jang & Chiriboga, 2011; Kim, Seo, & Cain, 2010; Lee, Moon, & Knight, 2004; Sin et al., 2010).

Koreans in S. Korea with better mental well-being in the current study had better health status than their counterparts. Mental well-being had a significantly positive association with health status (Heidrich, 1993). Negative mental health was strongly related to perceived health status (Han, Kim, Lee, Pistulka, & Kim, 2007; Lee, Moon, & Knight, 2004; Mui & Kang, 2006). Another study mentioned that mental health had a significant relationship with health status in both elderly Korean immigrants and elderly Koreans (Sin et al., 2010).

In both groups of Koreans, mental well-being was significantly associated with self-control (r = .40 and r = .29, ps < .01, U.S. and S. Korea, respectively), family functioning (r = -.39, ps < .01 and r = -.26, p < .05), social resourcefulness (r = .44, p < .01 and r = .26, p < .05), and health-promoting behaviors (r = .49 and r = .44, ps < .01). Koreans with better self-control had better mental well-being than their counterparts in this study. Another study indicated higher self-control was also associated with lower mental disorders among Vietnamese young people (Son, Yasuoka, Poudel, Otsuka, & Jimba, 2012). Also, self-control was positively correlated with well-being among 280 undergraduate students (Bowlina & Baer, 2012). A study of 859 Mexican descendants indicated that higher personal control was associated with lower depressive symptoms (Krause, Bennett, & Tran, 1989).

Koreans with better family functioning in this study had better mental well-being than their counterparts. From the study of Thai elderly, family support was significantly

correlated with psychological well-being (Thanakwang, Ingersoll-Dayton, & Soonthorndhada, 2012). Family relationship was related to mental health among Korean elderly immigrants (Lee, Moon, & Knight, 2004). Less family support was significantly related to higher levels of depression among 164 Korean immigrant adults with type 2 diabetes (Choi & Reed, 2013). Also, according to a study on 160 elderly Korean immigrants, Koreans who live with family were less likely to have depression than those who live alone (Lee & Holm, 2011). A study of 246 older Koreans reported that family support was significantly positively related to life satisfaction (Kim & Sok, 2012).

Koreans with more social resourcefulness had better mental well-being than those with less resourcefulness in this study. Better social support significantly decreased psychological distress in Korean immigrants (Min, Moon, & Lubben, 2005). Both positive and conflictive social support were correlated to mental health among elderly Korean immigrants (Lee, Moon, & Knight, 2004), which was consistent with other studies on first generation Korean immigrants (Han et al., 2007; Shin, Han, & Kim, 2007). Also, the relationship between participation on social activity and depression was significant (Jang & Chiriboga, 2011). Korean immigrant women who reported better social support showed decreased depression (Ayers et al., 2009) and some studies reported better social support resulted in better health outcomes and quality of life (Ganz et al., 2002; Lewis et al., 2001; Lim & Zebrach, 2006; Sammarco, 2001; Veenstra, 2000).

Koreans with better health-promoting behaviors had better mental well-being than their counterparts. A review study about exercise and well-being concluded that participants in physical activity interventions reported better health-related quality of life

and better mood states (Penedo & Dahn, 2005). Health-related behaviors were also related to mental health among new graduate nurses or undergraduate students (Melnyk, Hrabe, & Szalacha, 2013; Webb, Hirsch, Visser, & Brewer, 2013).

Among both Koreans in the U.S. and S. Korea, health-promoting behaviors were significantly correlated with self-control (r = .22, p < .05 vs. r = .30, p < .01), family functioning (r = -.33 vs. r = -.23, p < .05), and social resourcefulness (r = .41 vs. r = .31, ps < .01). Koreans who had better self-control had better health-promoting behaviors in the current study. Although there is a lack of study about the relationship between self-control and health-promoting behaviors, one study that included 1040 Hispanic adolescents showed that poor social self-control was related to using substances like cigarettes and alcohol (Pokhrel, Herzog, Sun, Rohrbach, & Sussman, 2013). Koreans who had better family functioning had better health-promoting behaviors in the current study. From the study of 2793 adolescents, higher family functioning was associated with more physical activity, less sedentary behaviors, and lower body mass index (Berge, Wall, Larson, Loth, & Neumark-Sztainer, 2013). Also, higher family functioning was significantly associated with lower rates of dieting and disordered eating behaviors in adolescents (Berge et al., 2012). A study examining mental health among low income women with young children reported lower family functioning was related to greater amounts of television viewing, which in turn impacted lack of leisure time physical activity (Li, Davison, & Jurkowski, 2012). Koreans who had more social resourcefulness had better health-promoting behaviors in the current study. In a study on 363 undergraduate students, health behaviors also had a significant relationship with social

support (r = .39) (Webb, Hirscha, Vissera, & Brewerb, 2013). Also, social support was correlated significantly with health-promoting lifestyles for Korean breast cancer survivors (Yi & Kim, 2013).

When reflecting on the theoretical underpinning of this study, the property of transition, operationalized as behavioral acculturation, was significantly associated with one of the transition conditions, operationalized as self-control (r = -.22, p < .05). Korean immigrants with better acculturation in behavioral aspects had higher self-control than their counterparts. However, another property of transition, cultural value acculturation, was not related to any transition conditions (ps > .05). Thus, behavioral adaptation for transitioning Korean immigrants is a more important component than cultural value. Additionally, all concepts of transition conditions, self-control, family functioning, and social resourcefulness, were desirably directly related to indicators of healthy transitions, health-promoting behaviors and mental well-being.

Research Question 3.

What are the differences in socio-demographic factors, self-control, family functioning, social resourcefulness, health-promoting behaviors, and mental well-being between Korean immigrants and Koreans in S. Korea?

The mean score of health-promoting behaviors for Koreans in the U.S. and Koreans in S. Korea differed significantly (t [190] = 3.387, p = .001). The total mean score of health-promoting behaviors for Korean immigrants in the U.S. was 68.9 (SD =

9.05), which was higher than that for Koreans in S. Korea (M = 64.6, SD = 8.43). Korean participants in the U.S. showed higher levels in health promotion activities, specifically, regular health check-ups, nutrition, and safety, than Koreans in S. Korea. Also, the mean scores of other subscales, including relaxation, substance use, and exercise, among U.S. Koreans were higher than or the same as those of S. Koreans although they were not statistically significant.

Korean immigrants generally reported a larger number of and more frequent health-promoting behaviors than S. Koreans in the current study. Behaviors regarding substance use and smoking were consistent with a previous study comparing Korean American adults and Korean adults in Seoul, which showed that current smoking rates among Korean Americans compared to Koreans in S. Korea were significantly lower (Song et al., 2004). More specifically, Korean American men were less likely to smoke compared to Koreans in Seoul (Ryu, Crespi, & Maxwell, 2012; Song et al., 2004); however, for women, the proportion of smoking among Korean immigrant women living in the U.S. was three times more than Korean women living in S. Korea (Song et al., 2004). Moreover, the rate of drinking in native Koreans was higher than the rate of drinking in Korean Americans (Ryu et al., 2012).

Inconsistent evidences in body mass and exercise were found; the body mass of Korean men in Seoul was lower than that of Korean American men after adjusting for age; that is, being overweight or obese among Korean Americans was more prevalent than among native Koreans (Song et al., 2004). Also, the rate of being overweight or obese in the past year among native Koreans was significantly lower than Koreans in the

U.S. (Ryu et al., 2012). Korean Americans were more likely to eat out than native Koreans, eat fewer green vegetables, fruits, and eggs, and eat less pork, noodles, and milk than Koreans in S. Korea (Song et al., 2004). However, Korean Americans reported having more concerns about consumption of a healthy diet than Koreans in S. Korea (Song et al., 2004). In a study comparing Koreans in S. Korea and in the U.S., an unacculturated and an acculturated group, Koreans in S. Korea were more likely to exercise than unacculturated Korean immigrants; but less likely than acculturated immigrants (Song et al., 2004). Another study comparing elderly Korean immigrants and elderly Koreans also reported that elderly Koreans were more likely to engage in physical activity than Korean immigrant elderly (Sin et al., 2009).

In the current study, a difference in mental well-being was not found between Koreans in the U.S. and Koreans in S. Korea (t [190] = .818, p = .414); but Sin and her colleagues (2010) reported that 53.4% of elderly Korean immigrants had depression as well as 63% of elderly Koreans in S. Korea. They explained that Korean immigrants living with a better social welfare system may have better mental health than elderly Koreans.

In this study, the mediator variables, self-control, family functioning, and social resourcefulness, were not different between the transitioning experienced group, Korean immigrants, and the non-experienced group, native Koreans, as well as mental well-being. However, the mean scores of health-promoting behaviors, especially subscales like regular check-ups, safety, and nutrition, in Korean immigrants who experienced transition were higher than native Koreans who did not experience transition. Thus,

immigration transition is not guaranteed to exacerbate immigrants' health prevalences, but it does present an opportunity for concern about their health promotion, safety, and nutrition.

Research Question 4.

What are the significant predictors among socio-demographic/immigration factors, acculturation, self-control, family functioning, and social resourcefulness of health-promoting behaviors and mental well-being for Koreans in the U.S.?

Research Question 5.

What are the significant predictors among socio-demographic factors, self-control, family functioning, and social resourcefulness of health-promoting behaviors and mental well-being for Koreans in S. Korea?

Based on the findings of the hierarchical multiple regression analysis of the predictors of U.S. Koreans' health-promoting behaviors, behavioral acculturation (β = .20, t = 2.25, p = .027), family functioning (β = -.27, t = -3.07, p = .003), and social resourcefulness (β = .39, t = 4.36, p = .000) were defined as predictors, explaining 27.5% of the variation in health-promoting behaviors. This finding indicates that Korean immigrants who were better acculturated in behavioral aspects and had better family functioning and social resourcefulness were more likely to practice better health-promoting behaviors. Also, this study found that self-control (β = .31, t = 3.89, p = .000), social resourcefulness (β = .30, t = 3.53, p = .001), and health-promoting behaviors (β

= .30, t = 3.37, p = .001) were included for predicting Korean immigrants' mental well-being, explaining 40.0% of the variation in mental well-being. Thus, this finding confirmed that social resourcefulness was the common strongest predictor that impacted U.S. Korean immigrants' health behaviors and mental health.

On the other hand, according to the study of Koreans in S. Korea, self-control (β = .29, t = 2.95, p = .004) and social resourcefulness (β = .31, t = 3.08, p = .003) were predictors of S. Koreans' health-promoting behaviors, explaining 18.6% of the variation in health-promoting behaviors; and the variable of these behaviors (β = .32, t = 3.03, p = .003) was a significant predictor of S. Koreans' mental well-being. Although social resourcefulness was not a significant predictor for mental well-being among S. Koreans, social resourcefulness was the most significant influence on health-promoting behaviors in both groups and mental well-being among U.S. Koreans.

The importance of social support on the impact of Koreans' health was found in many previous studies. In a study among 258 breast cancer survivors in Korea, the factor that most affected a health-promoting lifestyle was social support (Yi & Kim, 2013). Among Korean elderly immigrants, positive social support and family relationships were significant predictors of mental health, but perceived health status was not a predictor of mental health, which was similar to the finding of the current study (Lee, Moon, & Knight, 2004). Han et al. (2007) reported acculturative stress and perceived social support were key predictors of depression and Jang and Chiriboga (2011) reported that acculturation and social activity were significant predictors among first generation Korean elderly immigrants. Social support was a predictor of positive and negative

mental health among another group of Korean immigrants (Shin, Han, & Kim, 2007). Also, quality of life was related to family income and health status, which were key predictors of quality of life (Hsiao, Hsieh, Tseng, Chien, & Chang, 2012).

From this finding, behavioral acculturation, family functioning, and social resourcefulness were predictors of health-promoting behaviors and self-control, family functioning, and social resourcefulness were predictors of mental well-being among Korean immigrants. Thus, family and social supports were important facilitators for improving the health of Korean immigrants. On the other hand, self-control and social resourcefulness were predictors of health-promoting behaviors, and health-promoting behaviors were predictors of mental well-being among native Koreans. Although not congruent in the native Koreans' mental well-being, social resourcefulness was a dominant predictor of health-promoting behaviors and mental well-being among Koreans.

Research Question 6.

Do self-control, family functioning, and social resourcefulness mediate the relationship of acculturation on health-promoting behaviors among Koreans in the U.S.?

Based on the findings of the three equation model analyses and the Sobel tests, the relationship between behavioral acculturation and mental well-being was mediated by self-control (Figure 4.1), but family functioning and social resourcefulness did not mediate the relationships. No studies exist about the mediating effects of self-control and

family functioning on the relationships between acculturation and immigrants' health. Thus, this study will be an effective first step to identify the mediating effects of self and family on transitioning immigrants.

However, with a different finding from this study, previous studies showed that social support was a key factor for diminishing stress of life events as well as stress from immigration (Safda, Lay, & Struthers, 2003; Sasao & Chun, 1994; Yoon, Lee, & Goh, 2008). Also, social support mediated the relationship between acculturative stress and mental health among Korean immigrants (Kim, Han, Shin, Kim, & Lee, 2005), and social connectedness in the ethnic community completely mediated the relationship between acculturation and well-being (Yoon, Lee, & Goh, 2008). On the other hand, in this study, the mediating effect of social resourcefulness between acculturation and mental well-being was not found, which was consistent with some studies showing social support did not mediate the relationship between acculturation and depression or quality of life (Ayers et al., 2009; Lee et al., 2004; Lim, Yi, & Zebrack, 2008).

From the theory of transition for immigrants, the facilitating or inhibiting factors toward achieving a healthy transition, self-control, family functioning, and social resourcefulness mediate the relationships between property of transition and outcome indicators. This study showed that self-control had a mediating effect on the relationship between behavioral acculturation and mental well-being. Thus, self-control was a dominant facilitator or inhibitor on the mental health of immigration transition.

Findings Regarding Conceptual Framework

The conceptual framework was adapted from the middle-range theory of transitions (Meleis et al., 2000). Immigration was defined as situational transition with multiple directions. The properties of transition experiences were applied by the psychological adjustment, acculturation. In the Koreans' nature of transition, levels of acculturation and English proficiency were low. Self-control, family functioning, and social resourcefulness served as variables of transition conditions. These three variables of transition conditions did not differ significantly between Korean immigrants and native Koreans. Indicators of a healthy immigration transition were applied by health-promoting behaviors and mental well-being to check the immigrants' mastery of behaviors and personal well-being. Korean immigrants' health-promoting behaviors were better than those of Koreans in S. Korea; but mental well-being did not differ between Korean immigrants and Koreans in S. Korea.

The relationship between properties of transition and transition conditions was defined as the relationships between behavioral acculturation and cultural value acculturation and self-control, family functioning, and social resourcefulness. The results for Pearson's correlation analyses showed that only behavioral acculturation was negatively related to self-control (r = -.22, p < .05), which indicated that better behaviorally acculturated Korean immigrants had higher self-control. Additionally, the relationship between transition conditions and indicators of transition was defined as the relationships between self-control, family functioning, and social resourcefulness and health-promoting behaviors and mental well-being. The findings from this study showed

that self-control had a positive relationship to health-promoting behaviors (r = .22, p < .05) and mental well-being (r = .40, p < .01); which indicated better self-control was correlated to better health-promoting behaviors and mental well-being. Family functioning was significantly negatively associated with health-promoting behaviors (r = -.33, p < .01) and mental well-being (r = -.39, p < .01); which means that Korean immigrants with better family functioning showed better health-promoting behaviors and mental well-being. Social resourcefulness was also positively related to health-promoting behaviors (r = .41, p < .01) and mental well-being (r = .44, p < .01); which means that Korean immigrants having better social resourcefulness showed better health-promoting behaviors and mental well-being. Thus, all transition conditions were related to the indicators of transition.

The mediating effects of transition conditions on the relationships between properties of transition and indicators of transition were examined by the indirect effects of self-control, family functioning, and social resourcefulness on the relationships between acculturation and health-promoting behaviors and mental well-being. From the analyses using the three equation model and the Sobel test, self-control totally mediated the relationship between behavioral acculturation and mental well-being. On the other hand, the other variables of transition conditions, family functioning and social resourcefulness, did not mediate the relationship between acculturation and health-promoting behaviors and mental well-being.

Self-control is one of the important factors for adaptation, especially for Korean immigrants who are struggling to keep their original culture and to change and adapt to a

new culture (Tangney et al., 2004). Thus, to improve immigrants' health-promoting behaviors and mental well-being, the condition of their sense of self should be encouraged through cultural understanding.

Strengths and Limitations

This study focused on identifying the impact of immigration transitioning on health behaviors and mental well-being. It has several strengths; first, many of the studies regarding cultural understanding among Korean immigrants were focused on the relationships between causes and effects or predictors of health outcomes. However, the situation of immigration transition is complicated and multi-directed. This study addressed multiple components, the self, family, and social relationships, which impact transitioning on the health outcomes among culturally isolated immigrants. Thus, the findings from this study may be able to draw a big picture about understanding Korean immigrants and influence interventions that may improve their immigration lives. Also, the findings from this study will provide a good foundation for developing therapeutic nursing interventions.

Second, some previous studies that tried to understand immigrants' health outcomes and healthy lifestyles used only Korean immigrants or compared other U.S. immigrant subgroups. Although these studies were good for realizing and describing the situation of Korean immigrants, they failed to understand the impact of transitioning immigration to the U.S. on health behaviors and well-being among Korean immigrants. In order to comprehend effectively the changes of healthy life after immigration and the

impact of immigration transitioning on health outcomes, this study applied a comparative design of health behaviors and well-being between U.S. Koreans and S. Koreans.

Third, this study included only first generation Korean immigrants and S. Koreans. First generation immigrants have thoroughly experienced transitioning both linguistically and culturally. Also, native S. Koreans were selected from people who had not traveled over 6 months in the U.S. to minimize homogeneity.

Fourth, to increase the trustworthiness of the findings, reliabilities of assessment instruments are very important (Sitzia, 1999). The selected instruments were translated by a translation strategy and their reliabilities were examined through a pilot study and the current study. All measures have satisfactory reliabilities among both Koreans in the U.S. and in S. Korea. Thus, this study used the appropriate translated instruments for use in both Korean immigrants and native Koreans.

Lastly, overall powers of this study with a moderate effect size of .15 were .85 (S. Korea) and .95 (U.S.) from the G. Power, which were over the convention proposed power for general use to examine relationships of variables (Cohen, 1992).

With these strengths, some limitations of this study are left to overcome in further study. One of the limitations is that immigration is a transitioning process, and the length of transition is difficult to define. To most effectively understand the transitioning immigrants, the whole process of immigration should be examined before, during, and after immigration. Due to practical issues, such as time and expenses, this study employed the comparison of first generation Koreans in the U.S. as a post-immigration group and Koreans in S. Korea as a pre-immigration group to overcome a shortcoming of

a snapshot design. However, this study may fail to completely understand the changes and assimilations of immigrants to a new country.

A second limitation of generalizability still remains. This study used non-probability convenience and snowball sampling methods. Also, the main setting of this study for Korean immigrants was the central Texas and Austin area. Thus, due to methodological issues, the findings of this study may have difficulty in reflecting the transitioning experiences of all Korean immigrants.

A third limitation is that the properties of immigration of the middle-ranged theory for transition include multiple components; awareness, engagement, change and difference, transition time span, and critical points and events (Meleis et al., 2000). Although acculturation is the most common construct in immigration framework (Messias, 2002), this study used only acculturation for identifying the transition experience; it may not capture all features of immigration transitioning to the U.S.

The final limitation of note is that this study used self-administered questionnaires and had six individual questionnaires with socio-demographic and immigration information sheets for Korean immigrants. Thus, the participants may have lost focus on answering the questions.

Nursing Implications and Recommendations

This study provides important information about Korean immigrants who still need focus from health care professionals due to an underrepresentation in health and acculturation research. It also presents nursing implications for practice, research, education, and theory with recommendations for future study.

Nursing Practice

The vision of Healthy People 2020 released by the Department of Health and Human Services is "a society in which all people live long, healthy lives." The importance of the role of health care providers, especially those who primarily interact with vulnerable populations, should be better emphasized. Emphasizing their role may help to improve the overall health of immigrants and ultimately help achieve a healthier U.S. society. The present study's findings revealed that practice implications are crucial for lowly acculturated, limited English proficiency Korean immigrants. Also, health care providers should focus on promoting mental health and knowledge of health behaviors among Korean immigrants, particularly those who are still struggling to acculturate.

Korean immigrants are more likely to build their own ethnic enclave communities and seek health advice from their ethnic friends or family (Choi & Kim, 2010). Over 70% of Korean immigrants attended Korean churches (Hurh, 1998). Thus, health care providers who work with Korean communities should be more aware of Koreans' culture and unique characteristics, especially the different factors that contribute to the transitioning of Korean immigrants. Health care providers need to make it clear that

intensive and repeated education is needed to increase awareness regarding proper health information and health practices as well as resources available for advice and follow-up.

Health care providers should find more effective methods of approaching Korean first generation immigrants. From the finding of this study, Korean immigrants typically use Korean rather than English although they are physically living in an English speaking country. Korean immigrants distinctly lack in English proficiency, which in turn leads to unfamiliarity with the U.S. healthcare system, especially in such a rapidly changing era. Thus, despite using any strategy for providing health resources to Korean immigrants, the primary language used should be Korean. Another method of approaching Korean immigrants is using ethnic enclaves' communities as a main setting to deliver education or resources. Ethnic enclaves include Korean churches, Korean communities, Korean hobby assemblies, or Korean small businesses such as markets, hair salons, or restaurants. Also, to overcome linguistic barriers, telephone interpreters and bilingual interpreter staffs or volunteers need to be employed in primary health care settings.

Additionally, the findings of this study informed the current extent of Korean immigrants' health-promoting behaviors and mental health and their influencing factors. Korean immigrants were not lower in levels of health-promoting behaviors and mental well-being compared to S. Koreans; rather they were higher in levels of health-promoting activities like regular check-ups, safety, and nutrition. However, among those health-related behaviors, the biggest weak points for Korean immigrants in this study were relaxation and exercise. Korean immigrants showed a lack of effort and time for personal relaxation as well as physical activity. Thus, health care providers should highlight

increasing the allocation of time and efforts on relaxation and physical activity on a regular basis.

Moreover, this study found that social resourcefulness was significant for improving healthy behaviors and mental well-being among Korean immigrants. Also, self-control was a dominant mediator between behavioral acculturation and mental well-being. People with better self-control showed better behavioral acculturation. Thus, health care providers should be aware of the demand regarding social help and self development among Korean immigrants, seek to improve their areas of weakness, and try to provide new health information and social resources.

Nursing Research

The conceptual framework emerged from the middle-range theory of transitions for immigrants (Meleis et al., 2000) to explore the role of transition and acculturation on Korean immigrants' health life. Multiple components interfere and interact in the transitioning process. This study engaged multiple specific components, such as self, family, social, and culture. Hence, more empirical work is clearly needed to involve multiple components and to expand the findings from this study to multiple immigrant groups. To gain greater understanding of immigration transitioning, further study should include the measures reflected on various concepts, and replicated studies are needed to confirm the findings of this study or to check the misunderstandings from this study.

Second, to minimize the selection bias, randomized selection is recommended rather than convenience and snowballing sampling strategies, which bring bias into the study and limit the generalizability of the findings. The randomized selection may reflect

all possible participants with an accurate variety level of acculturation. Thus, this systematic recruiting strategy makes it a possibility to compare more or less advantageous groups in acculturation. This comparative study according to level of acculturation will help to illuminate specific health needs and to determine which interventions are needed in specific groups according to level of acculturation.

Additionally, this study included only first generation Korean immigrants, but further study is needed to expand the participants to the second generation and the next generation, although the U.S. immigration of Koreans is relatively new, only beginning approximately 100 years ago. The diversity of Korean Americans has been increased because of Korean immigrants married to non-Korean partners. Because of this fact, Korean immigrants cannot always be defined as a homogeneous group (U.S. Census, 2000). Thus, further study should include Koreans in any combination as well as first-, second-, and the next generation. Thus, a comparative study including these combination groups should add to the understanding of specific health needs and to determine long-term interventions.

Third, to identify the changes during immigration transition, the influencing factors before immigration, the experiences during immigration, and the changes after immigration should be examined. Thus, longitudinal studies may be effective to account for the element of time rather than the snapshot single point of data collection of cross-sectional design. Longitudinal design may identify the dynamic impact of the transition of immigrants' lives. Additionally, to completely understand Korean immigrants' health needs and personal health care during immigration transitioning, cultural approaches,

such as ethnographic studies, are needed by bilingual researchers in a Korean community setting.

Lastly, replicated studies are needed to confirm the relationships between transition properties, transition conditions, and transition indicators with a larger size of sample and broader spectrum of areas of the U.S. Also, the existing studies about immigration transition are lacking when defining the properties of transition, transition conditions, and indicators of transition, especially to immigrants with individually specific cultures. Thus, replicated studies are required to build the knowledge of immigration transition.

Moreover, the ultimate purpose of this study will be to develop culturally specific interventions for Korean immigrants to improve healthy lives in a new country. Thus, developing intervention programs and applying them to Korean immigrants will be one of the most important tasks. Based on the findings of this study, social resourcefulness was the key predictor of health-promoting behaviors and mental well-being among Korean immigrants. Thus, the strategies to provide better and effective social resourcefulness to Korean immigrants may be a central part in the plan of intervention among U.S. Koreans.

Nursing Education and Theory

The findings of this study may help health care educators as well as providers to increase awareness about cultural diversity. All health care providers commonly meet immigrants or culturally diverse persons as soon as they are assigned to health care fields. Thus, nursing educators need to teach nursing students how to approach differences and

how to find more appropriate nursing methods for people with diverse cultures and beliefs. The most key implication from these findings is realizing and admitting heterogeneity of Korean immigrants from other groups in the U.S.; immigrants are in the middle of assimilation to the U.S. culture yet retaining of their original culture. Also, individual immigrants have different levels of acculturation. Cultural awareness is very important to understand individuals coming from other cultures and may lead to better understanding of their behaviors and lifestyles.

Health care providers who already are in the health care field need to update their knowledge, attitudes, and beliefs regarding culturally diverse populations through continuing education programs. Thus, nursing educators who provide nursing continuing education should integrate cultural competence into nursing programs.

The literature review regarding the middle-ranged theory of transition for immigrants was not enough to draw relevant conclusions. Due to different focus studying areas, knowledge about each concept was difficult to build (Almendarez, 2007; Baird, 2009; Im & Choe, 2001; Im & Meleis, 1999a; Jadalla, 2007; Jones et al., 2003; Larson & McQuiston, 2008; Lindgren, 2004; McEwen et al., 2007; Messias, 2002). Thus, to develop the concepts of transition theory and to increase empirical and theoretical evidence, repeated and further studies are needed.

According to transition theory (Meleis et al., 2000), nursing therapeutics widely interact with other concepts of transition theory, nature of transition, transition conditions, and patterns of response. However, Im (2010) mentioned that the concept of nursing therapeutics needs to develop further. Thus, based on the findings of this study,

developing therapeutic nursing interventions and performing these interventions on Korean immigrants would be a good way to explore the concepts of nursing therapeutics in the middle range of transition theory.

Conclusions

Transition has complex and multidimensional patterns (Im, 2010); Korean immigrants transitioning to the U.S experience a specific and unique situation. Thus, the understanding regarding the impact of transitioning to the U.S. on Korean immigrants' health-promoting behaviors and mental well-being is crucial. Identifying the transitioning impact on Korean immigrants' health-promoting behaviors and mental well-being through multiple concepts, such as acculturation, self-control, family functioning, and social resourcefulness, was the primary purpose of this study.

Based on the findings, Korean immigrants had a low level of acculturation and limited English proficiency. The level of health-promoting behaviors of Korean immigrants was higher than that of S. Koreans. Social resourcefulness was a key predictor of health-promoting behaviors and mental well-being among Korean immigrants. Also, self-control was a crucial mediator on the relationship between behavioral acculturation and mental well-being.

Increasing acculturation and English ability for Korean immigrants as well as increasing social resourcefulness and self-control were found to be important in this study. Also, health care providers, educators, and researchers should have awareness about cultural demands among Korean immigrants, as well as culturally diverse populations to improve U.S. overall health.

This study provides an important first step regarding understanding mediating effects between cultural factors and health outcomes through the self, family, and society among transitioning immigrants. The findings help highlight the significance of social resourcefulness to Korean immigrants. Thus it may provide important reference information to practical health care providers as well as researchers who intend to develop intervention programs for Korean immigrants. Also, these findings provide essential information that all health care professionals can use to increase their awareness of the importance of appropriately treating individuals with different cultural perspectives as well as diverse populations coming from varied countries.

Appendices

Appendix A: Demographics of the Pilot Study (N = 30)

		Mean	*SD*
Age		43.8	10.26
Number of Family		3.1	1.06
		N	***%***
Gender	*Female*	19	63.3
Marital Status	*Married*	28	93.3
Education Level			
Middle School Graduate		1	3.3
High School Graduate		10	33.3
College Graduate or Higher		19	63.3
Current Employment Status	*Yes*	20	66.7
Family Income			
Somewhat Insufficient for Family		6	20
Sufficient for Essential Needs		18	60
More than Sufficient for Family		6	20
English Usage			
Never		6	20.0
Rarely		7	23.3
Sometimes		11	36.7
Usually		3	10.0
Always		3	10.0

		N	***%***
Length of Stay in the U.S.			
Less than 5 years		6	20.0
6-9 years		4	13.3
More than 10 years		20	66.7
Age upon Arrival to the U.S.			
5-11 years old		2	6.7
12-18 years old		2	6.7
Older than 19 years old		26	86.6
Have Health Insurance	Yes	21	70
Current Health Status			
Tend to be Unhealthy		3	10
Tend to be Healthy		24	80
Very Healthy		3	10
English Proficiency			
Not at all		3	10.0
Just a few words		3	10.0
More than a few words		10	33.3
Well		9	30.0
Very well		5	16.7

Appendix B.1: IRB Approval Letter for the Pilot Study

OFFICE OF RESEARCH SUPPORT

THE UNIVERSITY OF TEXAS AT AUSTIN

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FWA # 00002030

Date: 11/08/12

PI: Hyenam Hwang

Dept: Nursing

Title: Impact of Transitioning to the U.S. on Koreans' Physical and Mental Well-being

Re: IRB Expedited Approval for Protocol Number 2012-09-0089

Dear Hyenam Hwang:

In accordance with the Federal Regulations the Institutional Review Board (IRB) reviewed the above referenced research study and found it met the requirements for approval under the Expedited category noted below for the following period of time: 11/08/2012 to 11/07/2013 . *Expires 12 a.m. [midnight] of this date.* If the research will be conducted at more than one site, you may initiate research at any site from which you have a letter granting you permission to conduct the research. You should retain a copy of the letter in your files.

Expedited category of approval:

☐ 1) Clinical studies of drugs and medical devices only when condition (a) or (b) is met. (a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review). (b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

☐ 2) Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows: (a) from healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children2, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

☐ 3) Prospective collection of biological specimens for research purposes by non-invasive means. Examples:
- (a) Hair and nail clippings in a non-disfiguring manner.
- (b) Deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction;
- (c) Permanent teeth if routine patient care indicates a need for extraction.

(d) Excreta and external secretions (including sweat).
(e) Uncannulated saliva collected either in an un-stimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue.
(f) Placenta removed at delivery.
(g) Amniotic fluid obtained at the time of rupture of the membrane prior to or during labor.
(h) Supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques.
(i) Mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings.
(j) Sputum collected after saline mist nebulization.

☐ 4) Collection of data through non-invasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications).
Examples:
(a) Physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject's privacy.
(b) Weighing or testing sensory acuity.
(c) Magnetic resonance imaging.
(d) Electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography.
(e) Moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

☐ 5) Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis).
Note: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(4). This listing refers only to research that is not exempt.

☐ 6) Collection of data from voice, video, digital, or image recordings made for research purposes.

☒ 7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
Note: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.

☒ Use the attached approved informed consent document(s).

☐ You have been granted a Waiver of Documentation of Consent according to 45 CFR 46.117 and/or 21 CFR 56.109(c)(1).

☐ You have been granted a Waiver of Informed Consent according to 45 CFR 46.116(d).

Responsibilities of the Principal Investigator:

1. Report immediately to the IRB any unanticipated problems.

2. Submit for review and approval by the IRB all modifications to the protocol or consent form(s). Ensure the proposed changes in the approved research are not applied without prior IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subject. Changes in approved research implemented without IRB review and approval initiated to eliminate apparent immediate hazards to the subject must be promptly reported to the IRB, and will be reviewed under the unanticipated problems policy to determine whether the change was consistent with ensuring the subjects continued welfare.

3. Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to participate.

4. Ensure that only persons formally approved by the IRB enroll subjects.

5. Use only a currently approved consent form, if applicable.
   Note: Approval periods are for 12 months or less.

6. Protect the confidentiality of all persons and personally identifiable data, and train your staff and collaborators on policies and procedures for ensuring the privacy and confidentiality of subjects and their information.

7. Submit a Continuing Review Application for continuing review by the IRB. Federal regulations require IRB review of on-going projects no less than once a year a reminder letter will be sent to you two months before your expiration date. If a reminder is not received from Office of Research Support (ORS) about your upcoming continuing review, it is still the primary responsibility of the Principal Investigator not to conduct research activities on or after the expiration date. The Continuing Review Application must be submitted, reviewed and approved, before the expiration date.

8. Upon completion of the research study, a Closure Report must be submitted to the ORS.

9. Include the IRB study number on all future correspondence relating to this protocol.

If you have any questions contact the ORS by phone at (512) 471-8871 or via e-mail at orsc@uts.cc.utexas.edu.

Sincerely,

James P. Wilson

James Wilson, Ph.D.
Institutional Review Board Chair

Appendix B.2: Approval Letter for the Main Study

OFFICE OF RESEARCH SUPPORT

THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, Texas 78713 · Mail Code A3200
(512) 471-8871 · FAX (512) 471-8873

FWA # 00002030

Date: 07/12/13

PI: Hycnam Hwang

Dept: Nursing

Title: Impact of Transitioning to the U.S. on Koreans' Health Behaviors and Well-Being

Re: IRB Expedited Approval for Protocol Number 2013-04-0118

Dear Hyenam Hwang:

In accordance with the Federal Regulations the Institutional Review Board (IRB) reviewed the above referenced research study and found it met the requirements for approval under the Expedited category noted below for the following period of time: 07/10/2013 to 07/09/2014. *Expires 12 a.m. [midnight] of this date.* If the research will be conducted at more than one site, you may initiate research at any site from which you have a letter granting you permission to conduct the research. You should retain a copy of the letter in your files.

Expedited category of approval:

☐ 1) Clinical studies of drugs and medical devices only when condition (a) or (b) is met. (a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review). (b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

☐ 2) Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows: (a) from healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children2, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

☐ 3) Prospective collection of biological specimens for research purposes by non-invasive means. Examples:
- (a) Hair and nail clippings in a non-disfiguring manner.
- (b) Deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction;
- (c) Permanent teeth if routine patient care indicates a need for extraction.

(d) Excreta and external secretions (including sweat).
(e) Uncannulated saliva collected either in an un-stimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue.
(f) Placenta removed at delivery.
(g) Amniotic fluid obtained at the time of rupture of the membrane prior to or during labor.
(h) Supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques.
(i) Mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings.
(j) Sputum collected after saline mist nebulization.

☐ 4) Collection of data through non-invasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications).
Examples:
(a) Physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject's privacy.
(b) Weighing or testing sensory acuity.
(c) Magnetic resonance imaging.
(d) Electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography.
(e) Moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

☐ 5) Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis).
Note: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(4). This listing refers only to research that is not exempt.

☐ 6) Collection of data from voice, video, digital, or image recordings made for research purposes.

☒ 7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
Note: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.

☒ Use the attached approved informed consent document(s).

☐ You have been granted a Waiver of Documentation of Consent according to 45 CFR 46.117 and/or 21 CFR 56.109(c)(1).

☐ You have been granted a Waiver of Informed Consent according to 45 CFR 46.116(d).

Responsibilities of the Principal Investigator:

1. Report immediately to the IRB any unanticipated problems.

2. Submit for review and approval by the IRB all modifications to the protocol or consent form(s). Ensure the proposed changes in the approved research are not applied without prior IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subject. Changes in approved research implemented without IRB review and approval initiated to eliminate apparent immediate hazards to the subject must be promptly reported to the IRB, and will be reviewed under the unanticipated problems policy to determine whether the change was consistent with ensuring the subjects continued welfare.

3. Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to participate.

4. Ensure that only persons formally approved by the IRB enroll subjects.

5. Use only a currently approved consent form, if applicable.
   Note: Approval periods are for 12 months or less.

6. Protect the confidentiality of all persons and personally identifiable data, and train your staff and collaborators on policies and procedures for ensuring the privacy and confidentiality of subjects and their information.

7. Submit a Continuing Review Application for continuing review by the IRB. Federal regulations require IRB review of on-going projects no less than once a year a reminder letter will be sent to you two months before your expiration date. If a reminder is not received from Office of Research Support (ORS) about your upcoming continuing review, it is still the primary responsibility of the Principal Investigator not to conduct research activities on or after the expiration date. The Continuing Review Application must be submitted, reviewed and approved, before the expiration date.

8. Upon completion of the research study, a Closure Report must be submitted to the ORS.

9. Include the IRB study number on all future correspondence relating to this protocol.

If you have any questions contact the ORS by phone at (512) 471-8871 or via e-mail at orsc@uts.cc.utexas.edu.

Sincerely,

James P. Wilson

James Wilson, Ph.D.
Institutional Review Board Chair

Appendix B.3: Approval Letter for the Amendment

OFFICE OF RESEARCH SUPPORT

THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, Texas 78713 · Mail Code A3200
(512) 471-8871 · FAX (512) 471-8873

FWA # 00002030

Date: 08/02/13

PI: Hyenam Hwang

Dept: Nursing

Title: Impact of Transitioning to the U.S. on Koreans' Health Behaviors and Well-Being

Re: IRB Amendment Approval for Protocol Number 2013-04-0118

Dear Hyenam Hwang:

In accordance with the Federal Regulations for review of research studies, the Institutional Review Board (IRB) reviewed your requested amendment to the above referenced protocol and found that it met the requirements for approval.

Approval for your study expires on 07/09/2014. *Expires 12 a.m. [midnight] of this date.*

The following requested changes were approved:
Add Sangyun Choi as a research assistant

☒ Continue to use the original approved consent form(s).
☐ Use the attached approved informed consent document(s).
☐ You have been granted a Waiver of Documentation of Consent according to 45 CFR 46.117 and/or 21 CFR 56.109(c)(1).
☐ You have been granted a Waiver of Informed Consent according to 45 CFR 46.116(d).

Responsibilities of the Principal Investigator:

1. Report immediately to the IRB any unanticipated problems.

2. Submit for review and approval by the IRB all modifications to the protocol or consent form(s). Ensure the proposed changes in the approved research are not applied without prior IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subject. Changes in approved research implemented without IRB review and approval initiated to eliminate apparent immediate hazards to the subject must be promptly reported to the IRB, and will be reviewed under the unanticipated problems policy to determine whether the change was consistent with ensuring the subjects continued welfare.

3. Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to participate.

4. Ensure that only persons formally approved by the IRB enroll subjects.

5. Use only a currently approved consent form, if applicable.
   Note: Approval periods are for 12 months or less.

6. Protect the confidentiality of all persons and personally identifiable data, and train your staff and collaborators on policies and procedures for ensuring the privacy and confidentiality of subjects and their information.

7. Submit a Continuing Review Application for continuing review by the IRB. Federal regulations require IRB review of on-going projects no less than once a year a reminder letter will be sent to you two months before your expiration date. If a reminder is not received from Office of Research Support (ORS) about your upcoming continuing review, it is still the primary responsibility of the Principal Investigator not to conduct research activities on or after the expiration date. The Continuing Review Application must be submitted, reviewed and approved, before the expiration date.

8. Upon completion of the research study, a Closure Report must be submitted to the ORS.

9. Include the IRB study number on all future correspondence relating to this protocol.

If you have any questions contact the ORS by phone at (512) 471-8871 or via email at orsc@uts.cc.utexas.edu.

Sincerely,

James P. Wilson

James Wilson, Ph.D.
Institutional Review Board Chair

Appendix C.1: Informed Consent Form for Pilot Study

IRB USE ONLY
Study Number: 2012-09-0089
Approval Date: 11/08/2012
Expires: 11/07/2013

Consent for Participation in Research

Title: Impact of Transitioning to the U.S. on Koreans' Physical and Mental Well-being

Introduction

The purpose of this form is to provide you with information that may affect your decision as to whether or not to participate in this research study. The person conducting the research will answer any of your questions. Read the information below and ask any questions you might have before deciding whether or not to take part. If you decide to be involved in this study, this form will be used to record your consent.

Purpose of the Study

You have been asked to participate in a research study about the impact of transitioning to the U.S. on Koreans' physical and mental well-being. The purpose of this study is to be to test the language equivalence of the translated Korean instruments.

What will you to be asked to do?

If you agree to participate in this study, you will be asked to **COMPLETE SURVEYS;** sociodemographic/immigration profile, Korean American Acculturation Scale, Multigroup Ethnic Identity Measure-Revised, brief Self-control Scale, McMaster Family Assessment Devise - General Functioning, Social Resourcefulness Scale, Personal Lifestyle Questionnaire, and Warwick-Edinburgh Mental Well-Being Scale. This study will take approximately 30 minutes and will include approximately 30 study participants.

What are the risks involved in this study?

There are no foreseeable risks to participating in this study.

What are the possible benefits of this study?

You will receive no direct benefit from participating in this study; however, the findings of this study are important to improve understanding of immigrants' health behaviors and to develop health care plans for immigrants.

Do you have to participate?

No, your participation is voluntary. You may decide not to participate at all or, if you start the study, you may withdraw at any time. Withdrawal or refusing to participate will not affect your relationship with The University of Texas at Austin (University) in anyway.

If you would like to participate, please return the signed form to HYENAM HWANG. You will receive a copy of this form.

Will there be any compensation?

You will not receive any type of payment for participating in this study.

What are my confidentiality or privacy protections when participating in this research study?

This study is confidential to the researcher. Code numbers will be assigned to each individual questionnaire and they will be kept in a locked file accessible only by the researcher. All data will be identified with code numbers. Results of the study will be presented in aggregate.

Who do I contact of I have questions about the study?

Prior, during or after your participation you can contact the researcher **HYENAM HWANG** at **940-435-1572** or send an email to **hnhwang09@utexas.edu.**

Who do I contact about questions concerning your rights as a research participant?

For questions about your rights or any dissatisfaction with any part of this study, you can contact, anonymously if you wish, the Institutional Review Board by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu.

Participation

If you agree to participate, please return the signed form to HYENAM HWANG.

Signature

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights.

_____

Printed Name

_____ _____

Signature Date

As a representative of this study, I have explained the purpose, procedures, benefits, and the risks involved in this research study.

_____

Print Name of Person obtaining consent

_____ _____

Signature of Person obtaining consent Date

Appendix C.2: Informed Consent Form for the Main Study (English)

IRB Study Number: 2013-04-0118
Approval Date: 7/10/2013 Expires: 7/9/2014

Consent for Participation in Research

Title: Impact of Transitioning to the U.S. on Koreans' Health Behaviors and Well-Being

Principal Investigator and Faculty Sponsor Contact Number and UT Affiliation:

Principal Investigator:
Hyeman Hwang, RN, MSN
Doctoral Student
School of Nursing
The University of Texas at Austin
940-435-1572
hnhwang09@utexas.edu

Faculty Sponsor:
Tracie Harrison, PhD, RN,
Associate Professor
School of Nursing
The University of Texas at Austin
512-471-9085
tharrison@mail.nur.utexas.edu

Introduction

The purpose of this form is to provide you with information that may affect your decision as to whether or not to participate in this research study. The person conducting the research will answer any of your questions. Read the information below and ask any questions you might have before deciding whether or not to take part. If you decide to be involved in this study, this form will be used to record your consent.

Purpose of the Study

You have been asked to participate in a research study about how immigration from one country to another country affects your mental and physical health. We specifically want to know how you perceive your health-promoting behaviors and mental well-being after moving from Korea to the United States. We are also comparing the health promoting behaviors of people in South Korea to Koreans living in the U.S.

Therefore, we also want to know about the health promoting behaviors of people in South Korea.

What will you to be asked to do?

If you agree to participate in this study, you will be asked to answer questions on your background, immigration status, resources, health, and ethnic beliefs. These questions will be in the form of eight brief questionnaires that require you to check your response to a series of questions. It will take about 25 minutes to answer the questions. We hope to include about 140 people in the study.

What are the risks involved in this study?

Participation in this study is of very low risk to you. There are no foreseeable risks to those participating in this study. There have been occasions when people report feeling sadness after answering questions about their health. If you have any negative emotions after completing the survey and would like a referral for assistance, one will be provided. The University of Texas will not pay for any referrals nor will they reimburse you for any harm perceived to have occurred after participating in this study.

What are the possible benefits of this study?

You will receive no direct benefit from participating in this study; however, the findings of this study are important to improve understanding of immigrants' health behaviors and to develop helpful interventions for people who have moved from Korea to the United States. You may feel a reward from knowing you helped contribute to this knowledge.

Do you have to participate?

Your participation in this research study is entirely voluntary. You may decide not to participate at all or, if you start the study, you may withdraw at any time. Withdrawal or refusing to participate will not affect your relationship with The University of Texas at Austin (University) in anyway. You do not have to answer any question you do not wish to answer.

If you would like to participate, please return the signed form in the self-addressed, stamped envelope provided by Ms. **HYENAM HWANG**. Ms. Hwang's name, address and telephone number is found at the top and

bottom of this form. You will receive a copy of this form to keep for your records.

You may choose to complete the questionnaire in English or Korean. Please specify your language preference when speaking to Ms. Hwang.

Will there be any compensation?

You will not receive any type of payment for participating in this study.

What are my confidentiality or privacy protections when participating in this research study?

The answers you provide for this study are confidential. Code numbers will be assigned to each individual questionnaire, thereby keeping your identity protected. The questionnaires will be kept in a locked file accessible only by the researcher and her faculty sponsor. Data will only be identified with code numbers. Your name will not be associated with the data you provide. Results of the study will be presented in aggregate after analysis is complete. Members of the IRB do have the right to review the confidential records to ensure the study is being conducted appropriately. In this event your privacy would be respected to the extent permitted by law.

Whom to contact with questions about the study?

Prior, during or after your participation you can contact the researcher **HYENAM HWANG** at **(940) 435-1572** or send an email to **hnhwang09@utexas.edu.** If you are a participants in S. Korea, you can also contact the trained research assistant **SANGYUN CHOI** at **(010) 3801-5093** or send an email to **affirmative75@hotmail.com.** You may also contact Ms. Hwang's faculty sponsor, **Dr. Tracie Harrison,** by phone at **(512) 471-9085** or by email at **tharrison@mail.nur.utexas.edu.**

Whom to contact with questions concerning your rights as a research participant?

For questions about your rights or any dissatisfaction with any part of this study, you can contact, anonymously if you wish, the **Institutional Review Board** by phone at **(512) 471-8871** or email at **orsc@uts.cc.utexas.edu**.

Participation

If you agree to participate, please return the signed form to **HYENAM HWANG**. Place the consent form in the attached stamped envelope and mail it to:

In the U.S.,

Hyenam Hwang
1700 Red River St., Austin, TX 78703
School of Nursing, the University of Texas at Austin

In S. Korea,

Hyenam Hwang/Sangyun Choi
4F 794-4 Hannam-Dong, Youngsan-Gu, Seoul 140-210

Signature

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights.

_____
Printed Name

_____ _____
Signature Date

As a representative of this study, I have explained the purpose, procedures, benefits, and the risks involved in this research study.

_____
Print Name of Person obtaining consent

_____ _____
Signature of Person obtaining consent Date

Appendix C.3: Informed Consent Form for the Main Study (Korean)

IRB Study Number: 2013-04-0118
Approval Date: 7/10/2013 Expires: 7/9/2014

연구 참여 동의서

연구명: 미국으로의 이주가 한국인의 건강행위와 안녕에 미치는 영향

연구자 및 지도교수 연락처:

연구자:
황혜남, RN, MSN
박사과정생
School of Nursing
The University of Texas at Austin
940-435-1572
hnhwang09@utexas.edu

지도교수:
Tracie Harrison, PhD, RN,
Associate Professor
School of Nursing
The University of Texas at Austin
512-471-9085
tharrison@mail.nur.utexas.edu

연구에 관한 일반적 사항
이 자료는 귀하의 연구 참여 여부를 위한 결정에 영향을 미칠 수 있는 정보를 제공하기 위함입니다. 연구자는 귀하의 어떠한 질문에도 답할 것입니다. 아래에 제공된 정보를 읽고 연구 참여 여부를 결정하기 전에 어떠한 질문이라도 하여주십시요. 귀하가 본 연구에 참여하기로 결정하셨다면, 이 자료는 귀하의 연구참여동의서로 사용될 것입니다.

연구목적
귀하는 다른 나라로의 이주가 정신적, 육체적 건강에 미치는 영향에 대한 연구에 참여를 요청받으셨습니다. 본연구는 한국에서 미국으로 이주후 귀하가 지각하고 있는 건강증진 행위와 정신적 안녕에 대하여 알고자 합니다. 또한, 미국에 거주하는 한인 이민자와의 비교를 통하여 한국에 거주하고 있는 한국인의 건강증진 행위에 대하여 조사하고자 합니다.

연구참여자에게 요청되는 내용
귀하가 연구 참여에 동의하실 경우, 귀하는 귀하의 배경, 이민 상태, 자원, 건강, 그리고 민족적 신념에 대한 설문지에 답하시길 요청받으실 것입니다. 본 설문지는 8 개의 간단한 질문지 형식으로 답에 체크하시면 됩니다. 본 연구는 약 25 분 정도가 소요될 예정이며, 대략 140 명이 참여하게 될 것입니다.

연구를 통해 발생 할 수 있는 불편감
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서명

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_____
이름

_____ _____
서명 날짜

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_____
참여 동의서를 받은 사람의 이름

_____ _____
참여 동의서를 받은 사람의 서명 날짜

Appendix D.1: English Instruments

Part 1: Socio-demographic Information Questions

1. What is your date of birth?

Month/ Day/ Year So, I am ___ years old.

2. Are you ☐ Male ☐ Female

3. What is your marital status?

- ☐ Married
- ☐ Divorced/Separated
- ☐ Widowed
- ☐ Never Married/ Single

4. What is the highest level of education you finished?

- ☐ Never attended school
- ☐ Elementary/Grade school graduate
- ☐ Middle school graduate
- ☐ High school graduate
- ☐ College graduate
- ☐ Master's Degree completed
- ☐ Doctoral Degree completed

5. Are you currently?

- ☐ Working
- ☐ Unemployed

6. Our family income is…

- ☐ Insufficient for our family
- ☐ Somewhat insufficient for our family
- ☐ Sufficient for essential needs
- ☐ More than sufficient

7. How do you feel about your current health?

- ☐ I am very unhealthy
- ☐ I tend to be unhealthy
- ☐ I tend to be healthy
- ☐ I am very healthy

8. Number of persons living in current your household (EXCULD YOU) _____

9. Do you have health insurance?

- ☐ Yes
- ☐ No

Part 2: Immigration Information Questions

1. How long have you been living in the U.S.?

- ☐ Less than 1 year
- ☐ 1 - 2 years
- ☐ 3 - 5 years
- ☐ 6 - 9 years
- ☐ 10 - 14 years
- ☐ 15 - 19 years
- ☐ More than 20 years

2. How old were you when you arrived in the U.S.?

- ☐ 4 years old or less
- ☐ 5 - 11 years old
- ☐ 12 - 18 years old
- ☐ 19 - 22 years old
- ☐ Older than 22 years old

3. How often do you speak English at home?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always

4. How well can you speak English?

- ☐ Not at all
- ☐ Just a few words
- ☐ More than a few words
- ☐ Well
- ☐ Very well

Part 3: The Korean American Acculturation Scale

HOW MUCH DO YOU THINK ABOUT:	**Never**	**Seldom**	**About half the time**	**Usually**	**Always**
1. I speak Korean with other Koreans.	☐	☐	☐	☐	☐
2. I watch Korean language T.V. (and/or videos).	☐	☐	☐	☐	☐
3. I celebrate Korean holidays (e.g., Chusuk, Sul).	☐	☐	☐	☐	☐
4. Currently, my best friends are Korean.	☐	☐	☐	☐	☐
5. I use a Korean name instead of an English name.	☐	☐	☐	☐	☐
6. I listen to Korean music.	☐	☐	☐	☐	☐
7. My family cooks Korean foods.	☐	☐	☐	☐	☐
8. I speak Korean at home.	☐	☐	☐	☐	☐
9. It is easier to make friends with Koreans than Americans.	☐	☐	☐	☐	☐
10. I invite Koreans to my home rather than Americans.	☐	☐	☐	☐	☐
11. My thinking is done in Korean.	☐	☐	☐	☐	☐
12. I read books in Korean.	☐	☐	☐	☐	☐
13. I write letters in Korean.	☐	☐	☐	☐	☐
14. When I was a child, most of my friends were Koreans.	☐	☐	☐	☐	☐
15. I engage in Korean forms of recreation and social activities.	☐	☐	☐	☐	☐

HOW MUCH DO YOU AGREE WITH:	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
1. It is important to work hard for the future.	☐	☐	☐	☐	☐
2. One should think about one's social group before oneself.	☐	☐	☐	☐	☐
3. Older persons have more wisdom than younger persons.	☐	☐	☐	☐	☐
4. Parents should encourage their children to achieve for the honor of the family.	☐	☐	☐	☐	☐
5. One should follow the role expectations of one's family (parents, siblings).	☐	☐	☐	☐	☐
6. When one receives a gift, one should give a gift of equal or greater value.	☐	☐	☐	☐	☐
7. One should remain reserved and tranquil.	☐	☐	☐	☐	☐
8. Educational failure brings shame to the family.	☐	☐	☐	☐	☐
9. Maintaining interpersonal harmony is important.	☐	☐	☐	☐	☐
10. It is necessary to be patient to get what one wants.	☐	☐	☐	☐	☐
11. One should respect elders and ancestors.	☐	☐	☐	☐	☐
12. One should achieve academically to make parents proud.	☐	☐	☐	☐	☐
13. The ability to control one's emotions is a sign of strength.	☐	☐	☐	☐	☐
14. Modesty is an important quality for a person.	☐	☐	☐	☐	☐
15. It is important to have a good education.	☐	☐	☐	☐	☐
16. One should control one's public expression of emotions.	☐	☐	☐	☐	☐
17. One should not boast.	☐	☐	☐	☐	☐
18. Failure in work brings shame to the family.	☐	☐	☐	☐	☐

Part 4: The Brief Self-Control Scale

HOW YOU TYPICALLY ARE:	**Not at all**	**Not really**	**Undecided**	**Somewhat**	**Very much**
1. I am good at resisting temptation	☐	☐	☐	☐	☐
2. I have a hard time breaking bad habits	☐	☐	☐	☐	☐
3. I am lazy	☐	☐	☐	☐	☐
4. I say inappropriate things	☐	☐	☐	☐	☐
5. I do certain things that are bad for me, if they are fun	☐	☐	☐	☐	☐
6. I refuse things that are bad for me	☐	☐	☐	☐	☐
7. I wish I had more self-discipline	☐	☐	☐	☐	☐
8. People would say that I have iron self-discipline	☐	☐	☐	☐	☐
9. Pleasure and fun sometimes keep me from getting work done	☐	☐	☐	☐	☐
10. I have trouble concentrating	☐	☐	☐	☐	☐
11. I am able to work effectively toward long-term goals	☐	☐	☐	☐	☐
12. Sometimes I can't stop myself from doing something, even if I know it is wrong	☐	☐	☐	☐	☐
13. I often act without thinking through all the alternatives	☐	☐	☐	☐	☐

Part 5: The Family Assessment Device – General Functioning

HOW WELL DOES THIS STATEMENT DESCRIBE YOUR FAMILY:	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
1. Planning family activities is difficult because we misunderstand each other.	☐	☐	☐	☐
2. In times of crisis we can turn to each other for support.	☐	☐	☐	☐
3. We cannot talk to each other about the sadness we feel.	☐	☐	☐	☐
4. Individuals are accepted for who they are.	☐	☐	☐	☐
5. We avoid discussing our fears and concerns	☐	☐	☐	☐
6. We can express feelings to each other.	☐	☐	☐	☐
7. There are lots of bad feelings in the family.	☐	☐	☐	☐
8. We feel accepted for what we are.	☐	☐	☐	☐
9. Making decisions is a problem for our family.	☐	☐	☐	☐
10. We are able to make decisions about how to solve problems.	☐	☐	☐	☐
11. We don't get along well together.	☐	☐	☐	☐
12. We confide in each other.	☐	☐	☐	☐

Part 6: Social Resourcefulness Scale

WHEN YOU NEED HELP, HOW OFTEN DO YOU:	**Always**	**Usually**	**Some**	**Rarely**	**Never**
1. Tell someone how their help makes you feel?	☐	☐	☐	☐	☐
2. Look for professionals who could help you?	☐	☐	☐	☐	☐
3. Remind yourself that everybody needs help?	☐	☐	☐	☐	☐
4. Tell yourself that receiving help is not a sign of weakness?	☐	☐	☐	☐	☐
5. Tell someone who was not very helpful how they could be more helpful?	☐	☐	☐	☐	☐
6. Divide your requests for help among friends and family members?	☐	☐	☐	☐	☐
7. Try to change what a helper is doing if you think it will serve your needs better?	☐	☐	☐	☐	☐
8. Let friends or family members choose which of your needs they want to help with?	☐	☐	☐	☐	☐
9. Try to think of as many friends and family members as possible who could help you?	☐	☐	☐	☐	☐
10. Tell a helper exactly when, where, and what you want them to do?	☐	☐	☐	☐	☐
11. Remind yourself that it is OK to receive help?	☐	☐	☐	☐	☐
12. Accept the help you need?	☐	☐	☐	☐	☐
13. Try to keep the favors you give and the favors you receive about equal?	☐	☐	☐	☐	☐
14. Try to keep track of who has done you favors?	☐	☐	☐	☐	☐
15. Remind someone to do something they said they would do for you?	☐	☐	☐	☐	☐
16. Suggest a person who is trying to help you how they could help you better?	☐	☐	☐	☐	☐
17. Avoid asking the same people for help over and over?	☐	☐	☐	☐	☐
18. Remind yourself that those who help you now may need your help in the future?	☐	☐	☐	☐	☐
19. Remind yourself that it is OK to ask for help?	☐	☐	☐	☐	☐
20. Look for government, religious, or other charitable organizations that could give you help?	☐	☐	☐	☐	☐

Part 7: Personal Lifestyle Questionnaire

TO WHAT EXTENT DOES THE ACTIVITY APPLY TO YOU:	**Never**	**Occasionally**	**Frequently**	**Always**
1. See a health care provider for a check-up at least yearly.	☐	☐	☐	☐
2. Get together with friends.	☐	☐	☐	☐
3. Eat at regular times during the day.	☐	☐	☐	☐
4. Wear seatbelts while riding in an automobile.	☐	☐	☐	☐
5. Eat foods from each of the good groups daily (meat, milk, bread, fruits, and vegetables)	☐	☐	☐	☐
6. Communicate concerns with another person.	☐	☐	☐	☐
7. Drive after drinking beverages.	☐	☐	☐	☐
8. Update emergency numbers kept by the telephone.	☐	☐	☐	☐
9. Get adequate sleep.	☐	☐	☐	☐
10. Have a planned exercise program.	☐	☐	☐	☐
11. Climb at least five flights of stairs or walk one mile each day.	☐	☐	☐	☐
12. Stay within the speed limit while driving	☐	☐	☐	☐
13. Smoke cigarettes daily.	☐	☐	☐	☐
14. Add salt to food after preparation.	☐	☐	☐	☐
15. Take time to relax 15-20 minutes daily.	☐	☐	☐	☐
16. Drink alcoholic beverages per day.	☐	☐	☐	☐
17. Play sports, jog, or participate in other physical activity at least three times weekly.	☐	☐	☐	☐
18. Meet needs for intimacy.	☐	☐	☐	☐
19. Limit caffeine intake to 3 cups daily (includes coffee, tea, and colas)	☐	☐	☐	☐
20. Smoking inside the home	☐	☐	☐	☐
21. Have a dental check-up yearly.	☐	☐	☐	☐
22. Do a monthly self-breast exam (women only)	☐	☐	☐	☐
23. Maintain weight within desirable limits avoiding both overweight and underweight.	☐	☐	☐	☐
24. Avoid alcoholic beverages when taking medication.	☐	☐	☐	☐

Part 8: Warwick-Edinburgh Mental Well-being Scale

WHAT IS BEST DESCRIBES YOUR EXPERIENCE OVER THE LAST 2 WEEKS:	**Never**	**Rarely**	**Some times**	**Often**	**Always**
1. I've been feeling optimistic about the future.	☐	☐	☐	☐	☐
2. I've been feeling useful.	☐	☐	☐	☐	☐
3. I've been feeling relaxed.	☐	☐	☐	☐	☐
4. I've been feeling interested in other people.	☐	☐	☐	☐	☐
5. I've had energy to spare.	☐	☐	☐	☐	☐
6. I've been dealing with problems well.	☐	☐	☐	☐	☐
7. I've been thinking clearly.	☐	☐	☐	☐	☐
8. I've been feeling good about myself.	☐	☐	☐	☐	☐
9. I've been feeling close to other people	☐	☐	☐	☐	☐
10. I've been feeling confident.	☐	☐	☐	☐	☐
11. I've been able to make up my own mind about things.	☐	☐	☐	☐	☐
12. I've been feeling loved.	☐	☐	☐	☐	☐
13. I've been interested in new things.	☐	☐	☐	☐	☐
14. I've been feeling cheerful.	☐	☐	☐	☐	☐

Appendix D.2: Korean Instruments

Part 1: 사회인구학적 설문

1. 생년월일은? **_____년/_____월/_____일** **나이 (만 _____ 살)**

2. 성별 ☐ 남 ☐ 여

3. 결혼 상태는?

☐ 기혼
☐ 이혼 또는 별거
☐ 사별
☐ 미혼

4. 최종 학력은 무엇입니까?

☐ 정규교육을 받지 않았다.
☐ 초등학교 졸업
☐ 중학교 졸업
☐ 고등학교 졸업
☐ 대학교 졸업
☐ 석사 학위
☐ 박사 학위

5. 현재 직업은?

☐ 있다.
☐ 없다.

6. 가족의 수입은?

☐ 가족에게 많이 부족하다.
☐ 가족에게 약간 부족하다
☐ 가족의 기본 필요를 채우기에는 충분하다.
☐ 저축을 할만큼 충분하다.

7. 현재 본인의 건강상태에 대해 어떻게 생각하십니까?

☐ 나는 매우 건강하지 않다.
☐ 나는 건강하지 않은 편이다.
☐ 나는 건강한 편이다.
☐ 나는 매우 건강하다.

8. 현재 함께 살고 있는 가족은 몇 명입니까? (본인제외 _____명)

9. 건강보험을 가지고 있습니까?

☐ 네
☐ 아니오

Part 2: 이민 정보 설문

1. 미국에 거주한지 얼마나 되었습니까?

☐ 1 년 미만
☐ 1 - 2 년
☐ 3 - 5 년
☐ 6 -9 년
☐ 10 - 14 년
☐ 15 - 19 년
☐ 20 년 이상

2. 당신이 몇살때 미국에 왔습니까?

☐ 4 세 이전
☐ 5 - 11 세
☐ 12 - 18 세
☐ 19 - 22 세
☐ 22 세 이후

3. 집에서 얼마나 자주 영어를 사용하십니까?

☐ 전혀 사용하지 않는다
☐ 드물게 사용한다
☐ 가끔 사용한다
☐ 자주 사용한다
☐ 항상 사용한다

4. 영어를 얼마나 유창하게 말할 수 있습니까?

☐ 전혀 말할 수 없다
☐ 몇단어 정도 말할 수 있다
☐ 몇단어 보다는 많이 말할 수 있다
☐ 잘 한다
☐ 매우 잘 한다

Part 3: 문화적응 정도

어떻게 생각하십니까:	전혀	아니다	중간	대개	항상
1. 나는 한국사람과 이야기 할 때 한국어을 사용한다.	☐	☐	☐	☐	☐
2. 나는 한국 방송 (T.V./영화)을 본다.	☐	☐	☐	☐	☐
3. 나는 한국 명절을 지낸다 (예, 추석, 설).	☐	☐	☐	☐	☐
4. 현재 가장 친한 친구는 한국사람이다.	☐	☐	☐	☐	☐
5. 나는 영어 이름 대신에 한국 이름을 사용한다.	☐	☐	☐	☐	☐
6. 나는 한국 음악을 듣는다.	☐	☐	☐	☐	☐
7. 집에서 한국 음식을 만들어 먹는다.	☐	☐	☐	☐	☐
8. 나는 집에서 한국어를 사용한다.	☐	☐	☐	☐	☐
9. 미국 사람보다 한국 사람과 쉽게 친해진다.	☐	☐	☐	☐	☐
10. 나는 미국 사람보다 한국 사람을 집으로 초대한다.	☐	☐	☐	☐	☐
11. 나는 한국어로 생각한다.	☐	☐	☐	☐	☐
12. 나는 한국어로 된 책을 읽는다.	☐	☐	☐	☐	☐
13. 나는 한국어로 편지를 쓴다.	☐	☐	☐	☐	☐
14. 어렸을 때 가장 친한 친구는 한국 사람이였다.	☐	☐	☐	☐	☐
15. 나는 한국적인 취미 활동 또는 사회 활동을 한다.	☐	☐	☐	☐	☐

얼마나 동의하십니까:	전혀 아니다	중간	대개	항상
1. 미래를 위해 열심히 일하는 것이 중요하다.	☐	☐	☐	☐	☐
2. 사람은 자신보다 다른 사람 (사회) 을 먼저 생각해야 한다.	☐	☐	☐	☐	☐
3. 나이 든 사람은 젊은 사람보다 더 현명하다.	☐	☐	☐	☐	☐
4. 부모는 가족의 영광을 위해 자녀의 성공을 권장해야 한다.	☐	☐	☐	☐	☐
5. 가족의 역할 기대 (예, 부모/형제의 말) 를 잘 따라야 한다.	☐	☐	☐	☐	☐
6. 선물을 받았을 때, 받은 선물의 가치에 상응하는 것으로 보답해야 한다.	☐	☐	☐	☐	☐
7. 사람은 자제력이 있어야 하고 차분해야 한다.	☐	☐	☐	☐	☐
8. 공부를 못하는 것 (좋은 학교에 진학하지 못하는 것)은 가족에게 수치스러운 일이다.	☐	☐	☐	☐	☐
9. 다른 사람과 조화롭게 지내는 것이 중요하다.	☐	☐	☐	☐	☐
10. 원하는 것을 얻기 위해서는 참을성이 필요하다.	☐	☐	☐	☐	☐
11. 어른과 조상을 공경해야 한다.	☐	☐	☐	☐	☐
12. 부모님을 자랑스럽게 하기 위해 공부를 잘해야 한다.	☐	☐	☐	☐	☐
13. 자신의 감정을 잘 통제하는 것은 장점이다.	☐	☐	☐	☐	☐
14. 사람들에게 있어서 겸손은 중요한 자질이다.	☐	☐	☐	☐	☐
15. 좋은 교육을 받는 것이 중요하다.	☐	☐	☐	☐	☐
16. 사람은 공개적으로 감정을 표현하지 않도록 감정통제를 해야 한다.	☐	☐	☐	☐	☐
17. 사람은 뽐내지 말아야 한다.	☐	☐	☐	☐	☐
18. 직업세계에서의 실패는 가족에게 수치를 가져온다.	☐	☐	☐	☐	☐

Part 4: 자기 조절 도구

당신은 일반적으로 어떠합니까:	전혀 아니다		중간		매우 그렇다
1. 나는 유혹을 잘 견딘다.	☐	☐	☐	☐	☐
2. 나는 나쁜 습관을 고치는 게 어렵다.	☐	☐	☐	☐	☐
3. 나는 게으르다.	☐	☐	☐	☐	☐
4. 나는 부적절한 것을 말한다	☐	☐	☐	☐	☐
5. 나는 만약에 그것이 재미있다면, 나에게 해로울 지라도 한다.	☐	☐	☐	☐	☐
6. 나는 나에게 해로운 것은 하지 않는다.	☐	☐	☐	☐	☐
7. 나는 자제력을 좀 더 가졌으면 좋겠다.	☐	☐	☐	☐	☐
8. 사람들은 내가 자제력이 강하다고 말한다.	☐	☐	☐	☐	☐
9. 때때로 오락과 여흥은 쌓여있는 일로 부터 나를 해방시킨다	☐	☐	☐	☐	☐
10. 나는 집중하는 데 어려움이 있다.	☐	☐	☐	☐	☐
11. 나는 장기목표를 향해 효과적으로 일 할 수 있다.	☐	☐	☐	☐	☐
12. 때때로 나는무언가가 잘못되었다는 것을 알고 있으면서도 하고 있는 것을 그만 둘 수가 없다.	☐	☐	☐	☐	☐
13. 나는 종종 대안을 전혀 생각하지 않고 행동한다.	☐	☐	☐	☐	☐

Part 5: 가족 사정 도구 – 일반적 기능

당신의 가족에 대해 얼마나 동의하십니까:	매우	그렇다	아니다	전혀
1. 우리 가족은 서로에 대한 이해가 부족하기 때문에 가족이 함께 할 활동을 계획하는데 어려움이 있다.	☐	☐	☐	☐
2. 위기가 닥치면 서로에게 도움을 요청할 수 있다.	☐	☐	☐	☐
3. 우리 가족은 슬픈 감정을 서로에게 이야기할 수 없다.	☐	☐	☐	☐
4. 우리 가족은 가족 개개인을 있는 그대로 받아들인다.	☐	☐	☐	☐
5. 우리 가족은 두려움이나걱정에 대해 서로 얘기하기를 꺼린다.	☐	☐	☐	☐
6. 우리 가족은 서로에게 감정을 표현할 수 있다.	☐	☐	☐	☐
7. 우리 가족내에는 나쁜 감정들이 많이 있다.	☐	☐	☐	☐
8. 우리 가족은 우리가 있는 그대로 받아들여지고 있다고 느낀다.	☐	☐	☐	☐
9. 의사결정을 내리는 것은 우리 가족의 문제 중 하나이다.	☐	☐	☐	☐
10. 우리 가족은 문제를 어떻게 해결할 지에 대해 결정을 할 수 있다.	☐	☐	☐	☐
11. 우리 가족은 함께 잘 지내지 못한다.	☐	☐	☐	☐
12. 우리 가족은 서로를 믿는다.	☐	☐	☐	☐

Part 6: 사회 자원 도구

도움이 필요할 경우, 당신은 얼마나 자주….:	항상	자주	가끔	거의	전혀
1. 당신이 받은 도움에 대해 어떻게 느꼈는지 도움을 준 사람에게 말합니까?	☐	☐	☐	☐	☐
2. 당신을 도와 줄 전문가를 찾습니까?	☐	☐	☐	☐	☐
3. '모든 사람은 도움이 필요하다'라고 당신 자신에게말합니까?	☐	☐	☐	☐	☐
4. '도움을 받는 것은 나약함의 표시가 아니다'라고 당신 자신에게 말합니까?	☐	☐	☐	☐	☐
5. 어떻게 하면 더 도움이 될수 있는지에 대해 도움이 별로 안되었던 사람에게 말합니까?	☐	☐	☐	☐	☐
6. 가족과 친구에게 필요한 도움을 분배하여 요청 합니까?	☐	☐	☐	☐	☐
7. 만약 어떠한 방법이 당신의 필요에 더 나은 방법이라면 도움을 주는 사람이 그렇게 하도록 바꾸려고 합니까?	☐	☐	☐	☐	☐
8. 가족이나 친구가 당신의 필요 중 그들이 도와주고 싶은 것을 선택하도록 합니까?	☐	☐	☐	☐	☐
9. 당신을 도와 줄 수 있는 가능한한 많은 친구와 가족을 생각하려고 합니까?	☐	☐	☐	☐	☐
10. 정확하게 언제, 어디서, 어떤 도움이 필요한지를 도움을 주는 사람에게 말합니까?	☐	☐	☐	☐	☐
11. '도움을 받는 것은 괜찮다'라고 당신 자신에게 말합니까?	☐	☐	☐	☐	☐
12. 당신이 필요한 도움을 받아들이십니까?	☐	☐	☐	☐	☐
13. 당신이 받은 도움과 당신이 베푼 도움의 양이 같아지도록 노력합니까?	☐	☐	☐	☐	☐
14. 당신의 부탁을 들어 준 사람과 계속 가깝게 지내려고 노력합니까?	☐	☐	☐	☐	☐
15. 도움을 주는 사람에게 그들이 당신을 도와주겠다고 말했다고 상기시킵니까?	☐	☐	☐	☐	☐
16. 어떻게 하면 당신을 더 잘 도울 수 있는지를 도움을 주기 위해 노력하는 사람에게 제안합니까?	☐	☐	☐	☐	☐
17. 반복해서 같은 사람에게 도움을 요청하는 것을 피합니까?	☐	☐	☐	☐	☐
18. '지금 나를 도와준 사람도 미래에는 나의 도움이 필요할거야'라고 당신 자신에게 말합니까?	☐	☐	☐	☐	☐
19. '도움을 요청하는 것은 괜찮다'라고 당신 자신에게말합니까?	☐	☐	☐	☐	☐
20. 당신에게 도움을 줄 수 있는 정부기관, 종교단체, 또는 자선기관을 찾습니까?	☐	☐	☐	☐	☐

Part 7: 개인 생활방식 설문

당신의 생활 방식을 어느 정도 반영하고 있습니까:	전혀	가끔	자주	항상
1. 적어도 매년 정기검진을 위해 건강관리자를 만난다.	☐	☐	☐	☐
2. 친구들과 함께 어울린다.	☐	☐	☐	☐
3. 규칙적인 시간에 식사를 한다.	☐	☐	☐	☐
4. 차를 탈 때 안전벨트를 착용한다.	☐	☐	☐	☐
5. 매일 권장 식품군을 골고루 먹는다 (고기, 우유, 밥, 과일, 야채)	☐	☐	☐	☐
6. 고민거리에 관해 다른 사람과 이야기를 나눈다.	☐	☐	☐	☐
7. 2 잔 이상의 술을 마신 후 운전한다.	☐	☐	☐	☐
8. 새로운 응급전화번호를 알게 되면 전화기에 번호를 바꿔준다.	☐	☐	☐	☐
9. 적절한 수면을 취한다.	☐	☐	☐	☐
10. 계획된 운동 프로그램에 참여한다.	☐	☐	☐	☐
11. 매일 1 마일 (약 1.6 Km)을 걷거나 적어도 5 층 정도의 계단을 오른다.	☐	☐	☐	☐
12. 운전시 제한속도 기준을 유지한다.	☐	☐	☐	☐
13. 매일 1 갑 이상 흡연한다.	☐	☐	☐	☐
14. 완성된 음식에 소금을 첨가한다.	☐	☐	☐	☐
15. 매일 15~20 분 휴식을 위한 시간을 갖는다.	☐	☐	☐	☐
16. 매일 2 잔 이상의 술을 마신다.	☐	☐	☐	☐
17. 스포츠, 조깅 등의 어떤 종류의 신체 활동에 적어도 매주 3 회 이상 참여한다.	☐	☐	☐	☐
18. 친밀감에 대한 욕구를 충족하고 있다.	☐	☐	☐	☐
19. 카페인 섭취를 하루 3 잔 이내로 제한한다 (커피, 차, 콜라 포함)	☐	☐	☐	☐
20. 집안에서 담배를 피운다.	☐	☐	☐	☐
21. 매년 치과 정기 검진을 받는다.	☐	☐	☐	☐
22. 매달 유방자가검진을 시행한다. (여성만 답변)	☐	☐	☐	☐
23. 과체중과 저체중을 피하기위해 적정 체중을 유지한다.	☐	☐	☐	☐
24. 약을 복용할 때 알콜 섭취를 피한다.	☐	☐	☐	☐

Part 8: 정신적 안녕 도구

지난2 주동안 당신은 어떠셨습니까:	전혀	좀처럼	가끔	자주	항상
1. 나는 미래에 대해 낙관적 있었다.	☐	☐	☐	☐	☐
2. 나는 보람을 느꼈다.	☐	☐	☐	☐	☐
3. 나는 편안했다.	☐	☐	☐	☐	☐
4. 나는 다른 사람에게 흥미를 가지고 있었다.	☐	☐	☐	☐	☐
5. 나는 남는 에너지가 있었다.	☐	☐	☐	☐	☐
6. 나는 문제들을 잘 해결하고 있었다.	☐	☐	☐	☐	☐
7. 나는 명료하게 생각하고 있었다.	☐	☐	☐	☐	☐
8. 나는 나 자신에 대해 좋은 감정을 가지고 있었다.	☐	☐	☐	☐	☐
9. 나는 다른 사람들과 친밀하게 지냈다.	☐	☐	☐	☐	☐
10. 나는 자신감이 있었다.	☐	☐	☐	☐	☐
11. 나는 무언가에 대해 스스로 결정할 수 있었다.	☐	☐	☐	☐	☐
12. 나는 사랑하는 감정을 느끼고 있었다.	☐	☐	☐	☐	☐
13. 나는 새로운 것에 흥미를 가지고 있었다.	☐	☐	☐	☐	☐
14. 나는 활기찼었다.	☐	☐	☐	☐	☐

Appendix E: Permissions to Use Instruments

Re: Request: Permission of <The Korean American Acculturation Scale>

이미순 <uconn2009@daegu.ac.kr> 9/4/12

연락주셔서 감사드립니다.
사용해서도 됩니다. 훌륭한 논문 준비하시고, 좋은 결과 맺으시길 기원합니다.
이미순 드림

이름 : 이미순
회사 : 대구대학교
부서 : 교육대학원 교육학과(영재교육)
E-mail : uconn2009@daegu.ac.kr
회사전화 : 053-850-6593
팩스 : 053-850-5049
이동통신 : 010-4726-9036
홈페이지 :

Re: Request: Permission of <The Brief Self-Control Scale>

June P Tangney <jtangney@gmu.edu> 9/4/12

Hello,

You are more than welcome to use our measures. I am attaching the Brief Self-Control scale along with scoring information.

We do not yet have a Korean version. When you translate the measure, I would recommend that one person translate the items from English to Korean, and another person back translate the items to English. Then compare the back translated version to the original version. If you would like, we'd be happy to consult on the comparison and resolution of differences between the original and back translated versions.

Please do keep in touch and let us know how your research develops. I would be grateful for a summary of the results whenever they become available.

Best Wishes,

June T.

Your Order: **Evaluating and Treating Families: The McMaster Approach Christine E. Ryan, Duane S. Bishop, Gabor I.**

EuroBooks <barnesorders@books2anywhere.com> 9/7/12

Dear HYENAM HWANG
Thank you for shopping with EuroBooks.
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RE: Request: Permission of <The Social Resourcefulness Scale>

Stephen R. Rapp <srapp@wakehealth.edu> 9/7/12

Dear Hyenam: I agree to let you use the SRS in your research. Do you have a copy?
I would be interested in receiving and summary of the findings when you have them.
Good luck in your research

Steve Rapp, PhD
Professor
Departments of Psychiatry and Behavioral Medicine &
Social Science & Health Policy (Div. of Public Health Sciences)
Dermatology
Wake Forest University School of Medicine
1 Medical Center Boulevard
Winston-Salem, NC 27157
email: srapp@wakehealth.edu (Note: new email)
Ph: (336) 716-6995
Fax:(336) 716-6830

RE: Request: Permission of <The Personal Lifestyle Questionnaire by Dr. Muhlenkamp>

Debra Fisher <Deb.Fisher@asu.edu> 9/5/12

Good morning,

Attached please find the Personal Lifestyle Questionnaire. Please note a requirement of its usage is that it be cited. If you have questions, please let me know.

Thank you,
Deb

Deb Fisher
Research Advancement Manager
Arizona State University | Health Solutions
500 N.3rd Street | room 456 | MC 3020 | Phoenix, AZ 85004-0698
P 602-496-0931 | F 602-496-0544 | E deb.fisher@asu.edu

RE: Request: Permission of <The Warwick-Edinburgh Mental Well-being Scale>

Taggart, Frances <Frances.Taggart@warwick.ac.uk> 9/13/12

Dear Hyenam Hwang

Thank you for your completed form. We are happy for you to use WEMWBS for this. Please see my other email for links to useful websites including the questionnaire and guidelines for translations.

Best wishes

Frances

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